Hunter L. McQuistion
Wesley E. Sowers
Jules M. Ranz
Jacqueline Maus Feldman *Editors*

Handbook of Community Psychiatry

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Dedicated to all community psychiatrists: our colleagues—past, present, and future—serving tirelessly to advance quality, compassion, knowledge, and equality.

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Part I

Introduction and Background

1 The Present and Future of Community Psychiatry: An Introduction

Hunter L. McQuistion, Wesley E. Sowers, Jules M. Ranz, and Jacqueline Maus Feldman

This book aims to be a practical guide to twenty-first century community psychiatry. While academics have well traversed the territory of community mental health over the past decade, the most recent comprehensive book specifically focusing on American-based community psychiatry was published in 1996 (Vaccaro and Clark 1996). A long time coming, our volume owes tribute to and builds on the important contributions of many other works characterizing the principles and practices of community psychiatry. In this book, we amplify these works by describing five central pillars of community psychiatry. These pillars focus on the practice of contemporary community psychiatry, further organizing the discipline's ideals, science, and craft. But in addition to simply organizing an ever expanding fund of technical knowledge, because psychiatry, and especially community psychiatry, is so sensitive to social mores and economic flux, this volume also seeks to accomplish a timely reevalution of community psychiatric practice.

The rapid evolution of healthcare delivery is a key illustration. As of this writing during early spring 2012, global economic stress is producing dramatic systemic changes in the United States. In this context, the 2010 Patient Protection and Affordable Care Act (ACA) is unfolding, with a new reorganization of services into so-called health homes that might serve a multiplicity of tailored clinical needs. Simultaneously, on the level of basic clinical care, approaches that incorporate the still-developing concept of personal recovery in mental health have emerged. Embraced by a broad mental health consumer movement, from whence the original concept emerged, it is validating the work of many community psychiatrists and now influencing other behavioral health practitioners. Resultant clinical practice deemphasizes the societal assumption in recent decades that advances in medical technology, such as pharmacology, yield the best results

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and provide the base for the future of psychiatric care. Instead, a heightened understanding of person-centeredness is coming to light, refocusing on what a helping relationship can offer, while still applying scientific developments, such as those in psychiatric epidemiology, to help design practices that could eventually become evidence-based, thus further refining technique, particularly in the context of an increasing demand for documented clinical outcomes.

However, in addition to being a critically needed update, we believe that the project of constructing this *Handbook* documents a maturation of the discipline of community psychiatry. To start with, community psychiatric practice takes place in publicly funded organizational settings and there are an increasing number of psychiatrists working in these environments, highlighting a trend away from traditional private practice. As of 2002, early career psychiatrists were working 50% of weekly hours in publicly funded settings, as opposed to 17% in solo practice, with midcareer psychiatrists working 44 and 29% of their time, respectively, in these settings. This was an increase in the proportion of organizational vs. solo practice settings from 1996 at which time early career psychiatrists' reported 40% vs. 22%, 40%/22%, and midcareer psychiatrists reported 29% vs. 36% (Ranz et al. 2006). Similarly, though the process of development is ongoing (Sowers et al. 2011), chief executive officers of community-based behavioral health organizations have increasingly valued the role of medical director after several decades during which psychiatric collaboration was frequently minimal (National Council of Community Behavioral Healthcare 2011; American Association of Community Psychiatrists 2011). As described by Ranz in Chap. 48, the number of community/public psychiatry fellowship programs appears to be increasing, with 14 current programs, evidencing the appreciation of need for a sophisticated corps of psychiatrists able to work in American community-based settings, both traditional, such as community mental health centers, and nontraditional, such as not-for-profit programs outreaching to marginalized populations, such as people who are homeless. The new emphasis on integration and primary care increases the demand for a psychiatric workforce that can meet these challenges. Additionally, because of inclination, training, and experience, many community psychiatrists are also recognized as expert in working within systems. Accentuating its relevance, competency in systems-based practice is increasingly identified as a critical part of general psychiatric training (Accreditation Council for Graduate Medical Education 2007) with community psychiatry faculty therefore having a unique offering in building competency.

So, if community psychiatry has come of age as a discipline, with identifiably useful expertise to offer the profession and the entire mental health community, *a definition of just what it is* requires discussion. As far as back as 1963, there have been at least ten definitions of the evolving subspecialty (Szmukler and Thornicroft 2001; Jacobs 2011). We believe that the range and diversity of these proposed definitions reflect a reality that, as an area of defined expertise, community psychiatry has been a work in progress at least since the beginning of the 1960s, and the breadth of what self-identified community psychiatrists do is so broad, from academic work and public policy-making to a wide range of clinical endeavors, we are not surprised that an apparent cornucopia of definitions have been formulated, each accentuating an aspect of the work. Adding some complication to this has been the companion term, "public psychiatry." As discussed in detail in Chap. 48, while "public psychiatry" may not be wholly interchangeable with "community psychiatry" as a specialty, this moniker is frequently used to emphasize the tendency for community psychiatrists to work in publicly funded systems.

The 1985 founding of the American Association of Community Psychiatrists (AACP) (http://www.communitypsychiatry.org/default.aspx) has been an initial important step in coalescing professional identity. This organization has been a reference point within American psychiatry for collegial support, education, and the development of policy that reflects modern community mental health care. Endorsed by the AACP in 1993, Brown et al. (1993) articulated that community psychiatry is

> …a branch of psychiatry which emphasizes the integration of social and environmental factors with the biological and psychological components of mental health and mental illness. Community psychiatry is also a significant component of the more inclusive field of community medicine which focuses broadly on the prevention and treatment of illness for all individuals in a given community.

In 2001, Szmukler and Thornicroft analyzed the various definitions in great detail and emerged with a definition that they further refined in 2011 (Drake et al. 2011) in order to encompass "community mental health care."

> Community mental health care comprises the principles and practices needed to promote mental health for a local population by:
>
> 1. Addressing population-based needs in ways that are accessible and acceptable
> 2. Building on the goals and strengths of people who experience mental illness
> 3. Providing a wide network of supports, services, and resources of adequate capacity
> 4. Emphasizing services that are both evidence-based and recovery-oriented

Because this *Handbook* purposefully builds on prior work, we endorse these definitions, together, as complementary descriptions of community psychiatry. The former is global in scope, appropriately accentuating public health and the overall health of communities, otherwise termed the "macrosphere" (Rosen 2006). The latter definition denotes a focus on populations and the provision of effective resources to create accessible service systems that are oriented to assisting people to use their own strengths in pursuit of mental health. In this *Handbook,* we describe five central pillars of community psychiatry built on the two complementary definitions. These pillars focus on the practice of contemporary community psychiatry, further organizing the discipline's ideals, science, and craft.

Parts I and II: Introduction and Central Pillars

After the conceptual introductory chapter you are now reading, Jacqueline Maus Feldman's chapter recounts the historical evolution of community psychiatry. The five pillars are then discussed in detail in the *Handbook's* Part II ("The Basics: Central Pillars of Community Psychiatry") as separate chapters with real-life practical applications. Woven and often cross-referenced into subsequent chapters throughout the book, the pillars of Epidemiology, Public Health and Prevention, Financing, Advocacy, and Recovery and Person-centeredness are summarized as follows:

Epidemiology. Because the work of community psychiatry is necessarily population-focused, epidemiology arguably represents its matrical "basic science." As authors Dana March and Ezra Susser note in their chapter, "epidemiology helps provide an evidence base for community psychiatry, with an eye, ultimately, toward intervention." This chapter explains psychiatric epidemiologic methodology, describes key studies, and points to how identifying and ordering a multiplicity of causes give clues for interventions.

Public Health and Prevention. Characterizing the work of community psychiatry on a macrolevel entails viewing the work as public service, elevating community well-being. This phase of community psychiatry resonates with its commitment to reducing health disparities and, on a clinical level, promoting health education to enable people to feel in highest command of their wellness and recovery processes. In this chapter, Michael Compton describes the processes and challenges for community psychiatrists to exercise skills in prevention and in promoting public health.

Financing. Without funding, healthcare quite simply does not happen and because the bulk of community psychiatric service operates through public funding mechanisms, with inevitable political vicissitudes, it is necessary for all community psychiatrists to understand how cash flows. Without this understanding, practitioners—and the people they serve—are vulnerable to an erosion of empowerment to optimize service and outcomes. Anita Everett and her coauthors describe the basic mechanics of current financing, while also noting possible future trends, such as the ACA noted above, and how these trends might affect behavioral healthcare.

Recovery and Person-Centeredness. As we have mentioned, the emergence of the recovery movement and the resultant new emphasis on person-centeredness is arguably the most dramatic shift in clinical approach over the last decade. Wesley Sowers describes the current development of this concept and how it will continue to influence practice and policy.

Advocacy. Community psychiatrists have a tradition of working with underserved and marginalized populations, requiring them to be advocates for their patients, either on an individual basis in such activities as helping to access supportive housing, in facilitating service with other healthcare professionals, in working within organized medicine to influence legislation and public health policy, or in clinical administration, leveraging for improved services. Advocacy has always been at the heart of the subspecialty and is thus included as a pillar. Jeffrey Geller discusses the history of advocacy and the latter day issues it presents to community psychiatrists as they struggle, together with consumers and their families, with systems that are frequently suboptimal in responding to quality service and community well-being.

Part III: New Emerging Keys to Practice

Because we as editors are concerned both with community psychiatry as it exists today and committed to ensuring its future, Part III covers New Emerging Keys to Practice: those we believe will influence the way community psychiatry, and related practice environments, will move forward in coming years. These keys include general approaches to services, as well as innovative population-based clinical approaches and techniques. In the context of person-centeredness, it is fitting that Kenneth Minkoff's and Christie Cline's chapter on the Welcoming Service Environment begins this section, outlining how even very basic and apparently simple interventions in a service environment can profoundly help outcomes. We follow this with a chapter concerning person-centered treatment planning, by Neal Adams and Diane Grieder. This chapter expands on practical aspects of recovery-orientation, helping clinicians transform formal treatment planning into a collaborative and useful endeavor, particularly considering how the treatment plan has historically been reduced to being a regulatory ritual in many public sector settings. Paolo DeVecchio follows this with his discussion of Peer Service Providers as Colleagues, explaining how community psychiatrists can help enable self-identified peer clinicians integrate into the treatment team, in turn greatly strengthening service delivery. While peer clinicians represent a new human resource in behavioral healthcare, Avrim Fishkind and colleagues discuss the rise of electronic technology. This chapter describes, in Telepsychiatry and e-Mental Health, how these media are particularly relevant to psychiatry and how community psychiatrists will work in the future.

The last three chapters of Part III cover important, and expanding, treatment approaches. Paula Panzer and her colleagues cover how personal trauma history, increasingly recognized as ubiquitous, particularly in disaffiliated and impoverished populations, requires focused clinical attitude and approaches. Michael Garrett describes the emerging recovery-oriented technique of cognitive therapy specifically aimed at schizophrenia, offering new sources of hope for this population. Finally, David Pollack and his coauthors highlight the rapidly emerging role and techniques for psychiatrists in integrating primary care and behavioral health, long championed by many in community psychiatry and finally being adopted by policymakers.

Part IV: Practicing—Core Clinical Competencies and Techniques

Part IV of the *Handbook*, "Practicing: Core Clinical Competencies and Techniques" highlights eight basic competencies in a community psychiatrist's armamentarium. Russell Lim launches the section with the essential skill of cultural competence. Cultural competence is not only at the foundation of any population-based clinical intervention, but

as multiculturalism and American society are increasingly synonymous, it has critical application to generic behavioral health care. Clinical tools that must follow from this are described by Steven Goldfinger's and Jacqueline Maus Feldman's discussion of how clinical evaluation is always shaped by the setting in which it is performed. Igor Koutsenok then offers a full description in Motivational Interviewing about how knowing this technique, which should be viewed as second nature to psychiatrists, offers pathways to help patients move themselves along a line of motivation for change.

Because of the frequent complexity of a person's clinical presentation, the treatment team, a fundamental functional unit in community psychiatry, is dissected in detail by Carl Bell and his colleagues. As an outgrowth of this, while psychiatrists are not usually experts in the provision of all phases of psychosocial rehabilitation, relying on other team members, such as occupational therapists, to bring these techniques to full fruition, Richard Warner surveys the field and points to how community psychiatrists must have serious knowledge of technique and application of rehabilitation principles, integrating these approaches into practice. In a related manner, socially based clinical techniques are close to the heart of community psychiatric practice. Leslie Hart Gise and Benjamin Crocker describe how group techniques can be used for optimal outcome and Alison Heru's chapter, Family Treatment in Public Sector Settings, reminds us how we can foster change by approaching the core social group, the family. Richard N. Rosenthal then helps us begin to address another ubiquitous issue in community psychiatric practice, cooccurring substance use and mental health disorders (COD), carefully laying out basic techniques to work with this clinical issue.

Part V: Tried and True—Major Evidence-Based Practices

Part V, "Tried and True: Major Evidence-Based Practices," covers major universally accepted evidence-based interventions. While "all community psychiatry is local," the challenge is for practitioners and programs in community mental health to employ and adapt these interventions to their local service environments, matching them with appropriate populations. The section begins with a transition from Richard N. Rosenthal's chapter on basic COD techniques in Part IV to a comprehensive survey of evidence-based interventions by Christine Yodelis-Flores and her coauthors. This is followed by an exposition of Assertive Community Treatment, with a comparison to other forms of case management by Richard Gosche and colleagues, with subsequent descriptions of the supported employment model (Kim T. Mueser and Gary R. Bond), Behavioral and Physical Self-Management (Anthony J. Salerno and Paul J. Margolies), Psychopharmacology and Medication Adherence, with particular focus on how medication aids in the recovery process (Ron Diamond), and finally, a multifaceted discussion of family psychoeducation by Susan Deakins and William McFarlane.

Part VI: Heroes—Promising Practices and Interventions

Whereas evidence-based practices (EBPs) are well established, there are also other "Heroes: Promising Practices and Interventions," as explored in Part VI. These chapters discuss interventions that are either just entering into the realm of being EBPs, hold high creative promise in doing so, or represent approaches not typically identified with American mental health care. It is led off by Sam Tsemberis and colleagues' in-depth discussion of approaches to supported housing, concentrating, as well, on the role of psychiatrists in these programs. It is followed by Alan Doyle's description of the Fountain House psychosocial clubhouse model and its relationship to community psychiatry. Deepika Sabnis and Rachel Lipson Glick then examine community-based crisis services and hospital alternatives—increasingly important in an era of fiscal belt-tightening. And because we hope the *Handbook's* material is useful beyond the systems born in the United States, to the global

"community" of community psychiatrists, Alan Rosen and his colleagues have reported on the status of behavioral health interventions internationally. These, in turn, could inform policy and seed initiatives in elsewhere on the globe.

Part VII: Applied Public Health—Special Populations

Here is where psychiatric epidemiology most clearly relates to practice. Through its population-based orientation, community psychiatry has developed evolving models of service to special populations that are underserved by traditional behavioral health services. Arguably, this has quintessential embodiment in homeless populations, as discussed by Hunter L. McQuistion in this section's first chapter. The chapter also notes established and emerging practices, such as Critical Time Intervention, that have themselves influenced broader behavioral healthcare. Following this is Fred Osher's description of public health issues and diversion strategies concerning a phenomenon of transinstutionalization—people with serious mental illnesses, mostly those without social supports, being relegated to the criminal justice system. Mathew N. Goldenberg and colleagues then extend Paula Panzer's discussion of trauma in Part IV to this century's newly realized skill-set, managing the psychiatric sequelae of disasters and their effect on communities. Susan Rathmell and her coauthors go on to describe the mental health issues of veterans and their families entwined by a currently ever-growing reality of combat experience. Ronald Hellman then discusses Clinical Issues and Programming for Lesbian, Gay and Transgender Populations, emphasizing how these populations have special needs and strengths, requiring special cultural competence.

The following two chapters of Part VII survey both ends of the life cycle: how community psychiatric approaches lend special value to practice among children and adolescents (Charles Huffine) and elders (Carl Cohen and Fayez Ibrahim). Finally, community and public psychiatry is often associated with urban environments, yet Paulette Marie Gillig and colleagues end the section by examining the challenges of delivering quality community-based care in rural settings.

Part VIII: Making It All Work—Systems and Administration

The practice of community psychiatry is inextricably connected to systems, whether as "micro" as a treatment team in a public shelter or as "macro" as a state mental health system. In order to succeed, it is necessary for community psychiatrists to not only understand how to work within systems, but to adaptively exploit them for their patients, even if as clinical psychiatrists they are without direct administrative or policymaking roles. Anita Everett and colleagues' "Pillars" chapter in Part II on Financing lays groundwork and this section fully elaborates on understanding how systems function. It begins with Michael Hogan's description of the process and lessons of leading the President's New Freedom Commission on Mental Health as related to the essential leadership task of rethinking and transforming services. There is a role for psychiatry in leadership and Jacqueline Maus Feldman's following chapter on this topic offers valuable tools to achieve this. Wesley Sowers then leads us into the related discussion of the art and science of resource management and services administration, logically transitioning to Stephen Rosenheck's and Jules Ranz's chapter on the evolving role of the medical director in community mental health.

The final chapters of this section discuss two other important and emerging facets of clinical administration. As Robert Savage and his colleagues describe in their chapter, Program Evaluation and Quality Management, the demand for measurable outcomes is advancing inexorably, along with skills acquisition in quantitative quality management, such as continuous quality improvement. As watchdogs in quality person-centered care in publicly funded behavioral health, it is indispensable for community psychiatrists to understand this. On a more involved level, this moves to expertise in services research, as Mario Cruz discusses next, enabling community

psychiatrists to comprehend how using rigorously derived evidence can further legitimize clinical intuition and experience.

Part IX: Shaping the Future—Education, Workforce, and Professional Development

An absence of training and education yields no future and we are at a time when the workforce in behavioral health does not meet public need, particularly with psychiatrists in short supply. Part IX discusses current issues and opportunities in the training and building of a cohort of community psychiatrists. The accent is on extending the reach of traditional training and education, preparing psychiatrists to thrive in an evolving service environment. Kathleen A. Clegg speaks to issues in current medical school curricula, proceeding to suggest modifications that better prepare medical students to manage systems-based treatment and then discusses approaches to residency training with concentrations in community psychiatry. Jules Ranz describes the growing range of postresidency fellowships in public and community psychiatry, an optimistic harbinger of the discipline's future. Perhaps at the core of psychiatric training is the role of the mentor. Joel Feiner articulates how mentoring and supervision can be applied for support during all phases of a professional career, helping us to be enlightened colleagues. Finally, H. Steven Moffic and Herb Bateman discuss ethical issues in community psychiatry and offer policies and procedures to guide practice.

Welcome to the Future: We're Glad You Made It[1]

In an important sense, the future begins at the moment of reading this sentence.

It presents a challenge and an opportunity. Practice in community behavioral health will undergo reorganization over the next decade. Sufficient economic resources, always tough to acquire in the public sector, will become even more difficult to adequately capture at least in the near future. The field will gear itself to measurable outcomes using services and clinical technology. Simultaneously, program survival will depend on being as economical as possible, likely leading to "pay for performance" methodologies. This will require financing strategies that hold hope for efficiency yet combined with true person-centeredness, including some forms of capitation (see Chap. 5), as well as the development of medical homes with optimally integrated behavioral health, along with an increased use of peer workers (who are both economical and recovery-oriented).

As Jacobs (2011) points out, the ACA operationalizes a vision of dramatically increased ranks of Americans with health insurance, leading to a growing need for human resources in behavioral healthcare—even as available workers in the field are now at a premium, especially psychiatrists. Meeting this human resource need requires community psychiatrists to be confident of their knowledge and skill, even as they garner support from organizations like the AACP. To further assist in this effort, helping the discipline reach the next phase in development, AACP has launched a methodical process to create a formal competency certification in community psychiatry. We hope this book is an important additional tool equiping all psychiatrists to work effectively in any clinical, administrative, policymaking, or academic role within systems of behavioral healthcare.

As noted, and as you will see detailed throughout this book, community psychiatry with its allied colleagues, has an opportunity to not only continue to adapt, but we believe, thrive, as behavioral health resources move to newer models.

An important example arises from the concept of the medical or health home, whose creation increases focus on primary care and prevention. Our view is that there will be increasing opportunities for community psychiatrists to advance their special skills in negotiating systems so as to catalyze greater integration of health and human services toward improving the

[1] The Firesign Theatre, 1971

wellness of whole communities. While it is unquestionable that psychiatrists will need to show that they are contributing to results-based productivity, they can help show the way, leading the psychiatric profession, and medicine in general, as they use knowledge derived from the Central Pillars and the tools the *Handbook* offers. In this way, the *Handbook* can add strength to a community psychiatrist's dedication and experience, helping each one of us to become the authors of the future.

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2 History of Community Psychiatry

Jacqueline Maus Feldman

Introduction

Since antiquity, mental illnesses have proven challenging for individuals suffering with them, for families who wish to support them, and for communities in which they live. Evolution in the development of community services and supports has been predicated on the understanding or interpretation of mental illness, aided by acceptance and innovation, but often anchored in ignorance, stigma, and short-sightedness. Regardless of how one defines community psychiatry (by provider, by setting, by duration of care, by diagnosis, by set of principles, by finances/payer of services), multiple facets are important in the evolutions of the field. A historical review of community psychiatry is imperative to comprehending the variables that impact the lives of those touched by mental illness, and may suggest how systems of care should be organized to enhance recovery.

As early as the Neolithic era, evidence exists that many attempts were made to treat and cure mental illness. Skeletal remains with large burr holes in their skulls from that era have been speculated to reflect interventions in brain disorders (Brothwell 1981). Records from ancient Egypt reported clinical presentations of depression and somatization, with trials of magical spells, applications of body fluids, use of hallucinogens, and religious retreats to ameliorate these conditions (Nassar 1987). Hindu religious texts denoted interpretations of mental illness as reflections of supernatural beings imbued with magical powers, or as a result of the body being out of balance; the religious community responded with application of prayers, herbs, or persuasion (an early attempt at therapy?) (Bhuga 1992). Bodily imbalance was also embraced as an explanation for mental disorders by the ancient Chinese; treatment like herbs and acupuncture sought to bring these back in alignment (Yizhuang 2005). Ancient Jewish cultures viewed mental illness as a reflection of a discordant relationship with G-d. Eschewing theories that the etiologies of mental illness were supernatural or divine in nature, Hippocrates recommended close observation, accurately described numerous mental maladies, noted contributory roles of environment, diet, and life style, and suggested treatment be focused on balancing bodily fluids. Ultimately, Plato embraced the theory that all mental illness was predicated on physical problems, and a Greek physician became the first to suggest humane treatment, including releasing agitated patients from restraints (von Staden 1996).

During the Middle Ages, the Quran reflected the need to treat those who were mentally challenged with humane protectiveness; some Muslim physicians encouraged the development of trusting counseling relationships and developed patient-centered, supportive asylums from 700 to 200 AD (Million 2004). Unfortunately, such forbearance was not as

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readily apparent in Europe during the Middle Ages, where interpretation of mental illness again became tied to a "mixture of the divine, diabolical, magical and transcendental" (Million 2004, p. 38). Humors, spirits, and demons were all thought responsible for mental disorders, and the suffering individual was thought to be morally unfit and suffering from sin, punishment for a lapse in his relationship with G-d, or possessed by the devil. During this time, the challenge of providing care for these individuals fell to families, although in England the courts often provided additional supports. Others were not so lucky, and were the target of witch hunts; the "more" fortunate were removed (or pushed) from family care, shipped off and restrained in almshouses, jails, or mad houses (Wright 1997).

The Age of Enlightenment marked a resurgence in the belief that mental illness was predicated on physical not moral problems, though patients were often seen as wild animals, needing restraint and physical punishment to ameliorate their animalistic furies. In America in the 1700s the general medical Pennsylvania Hospital began to offer services for those with mental illness (though in its basement), and colonial Virginia opened the first mental health asylum in Williamsburg designated specifically for citizens with mental illness. Toward the end of the 1700s, the moral treatment movement occurred, with leadership provided by Phillipe Pinel in France, and Tuke and the Quakers in England. Rees (1987) describes Pinel's philosophy:

> the insane came to be regarded as normal people who had lost their reason as a result of having been exposed to severe psychological and social stress. These stressors were called the moral causes of insanity and moral treatment relieves the patient by friendly association, discussion of his difficulties and the daily pursuit of purposeful activity; in other word, social therapy, individual therapy, and occupational therapy (pp. 306–307).

Before further exploring moral treatment in the United States and the evolution of psychiatric care that eventually culminated in expansion of community psychiatry, a brief sojourn into the history of Geel is imperative, as it illustrates the potential and capacity for a community to embrace and support people with mental illness in a recovery-oriented fashion. Over 700 years ago, a city in Belgium, Geel, established a system of community care for those with mental illness that has been sustained, in some fashion, through this very day. By legend, it is told that in the sixth century Dimphna, the daughter of an Irish king, fled to the forests of Geel to escape her recently widowed father, who in a grief-stricken delusion, demanded she marry him. Instead of acquiescing, she chose to be beheaded; named the patron saint of those with mental illness, the site of her martyrdom became a chapel that witnessed cures of mental illness. Pilgrims seeking miracle cures overwhelmed the region and the church onsite became their housing; at the bequest of the overwhelmed church, villagers from the surrounded area open their homes, and thus began the tradition of "integrated, community residential care" (Goldstein and Godemont 2003). These often trans-generational foster families provided mental health care and support with virtually no formal training, and by the late 1930s over 3,800 boarders were living with Geel families; for the most part "the role of the family as caretaker, teacher, natural supportive parent, and behavioral model allows the boarder to function in the normal social world" (p. 449).

By the 1950s, however, boarder populations began to decline. A study was initiated in Belgium in the mid-1960s to study Geel and its mental healthcare system, as its original leader was expressing fears that the Colony would dwindle away. Instead, legislation has elevated the Colony to autonomous status, and new physician administrators have inspired evolution in the services rendered. More recent research reflects the majority of boarders are male, ages ranging from 15 to 75, half are mentally retarded, over 20% diagnosed with schizophrenia. Non-adherence rates are low, and a relatively low incidence of violence is reported. Each family has a psychiatric nurse assigned to them, and hospitalization is available if necessary. Of interest, boarders are not kept out of pubs (taverns), which are "an important part of community social life" (p. 455). Historically largely agrarian (which offered boarders opportunity for farming jobs), Geel is now industrialized; boarders still are "given the opportunity to do meaningful work" (p. 456). Geel

> acknowledges and accepts the human needs of the boarders and responds to those needs rather than acting on unfounded or exaggerated fears… because of their exposure to and experience with mental illness, the entire population protects rather than fears members of their community who are mentally ill. The living legend of Geel offers an opportunity to learn lessons that can encourage effective mental health care—community caring in caring communities (p. 456).

Unfortunately, communities like Geel were difficult to replicate, but dedicated individuals continued to strive to enhance mental health care in America in the mid-1800s. Inspired by Phillippe Pinel, Dorthea Dix promulgated moral treatment reform in America. After failing to convince the federal government to embrace responsibility for those with mental illness (in 1854 President Franklin Pierce vetoed a bill that would have set up federally funded construction of mental hospitals), Dorthea Dix continued her campaign, begun in the 1840s, to convince state governments "to provide that which many of the ill patients lacked: stable housing, nutritious meals, supportive care in kind and calming environment…to provide asylum for those needing support and nurturing to cope with their mental illness" (Feldman 2010, p. 193). Asylums were constructed and patients admitted and "treated" (with kindness, housing, food, and work). While initially capable of providing succor and support, the institutions were quickly overwhelmed by an influx of society's less fortunate (those with chronic medical illnesses like syphilis and dementia, orphans, and those who were impoverished); battling excessive caseloads and inadequate funding, humane treatment floundered in asylums, and patients were warehoused with little to no treatment or care offered (Crossley 2006). Although the introduction of ECT and insulin shock therapy ensued, many patients spent the remainder of their lives incarcerated in state hospitals. By the mid-1950s, the numbers of patients housed in American mental institutions peaked at over 550,000.

In the late 1800s and early 1900s, other reforms and treatments in mental health blossomed that set the stage for the evolution of institutional care ultimately transitioning to community-based care. The Mental Hygiene movement was led by Clifford Beers, a brilliant young financier who developed bipolar disorder, attempted suicide and spent 3 terrible years in a state hospital in Connecticut. Against the recommendation of most of his friends and supporters, he felt compelled to document his course of care (even going so far as to get himself locked down on the freezing violent ward), hoping to improve care, demonstrate to the general public that people with mental illness could recover, and to prevent mental illness and institutionalization. He was instrumental in the formation of the National Committee on Mental Hygiene, which ultimately evolved into the NMHA, now known as Mental Health America. This group performed and published surveys of state hospitals and patient treatment and treatment conditions, and proved instrumental in changing conditions in state hospitals across the nation (Beers 1981).

In the late 1940s a clubhouse model of psychosocial rehabilitation burst on the scene in New York City. Based on the belief that those with mental illness were capable of helping each other, The Fountain House (detailed in Chap. 30), a membership organization run for and by persons with mental illness, was established. It aimed to achieve many things for its members that became the backbone of the principle of psychosocial rehabilitation: establishing relationships, increasing productivity and self-confidence, re-entry into society, learning self-advocacy, and fighting stigma. It has spawned numerous organizations locally and has served as a role-model for many as they develop their own club-house models (Fountain House 2011).

The use of psychoanalysis to treat patients with neuroses blossomed in the 1930s and 1940s, and the creation of a veteran population afflicted by PTSD in World War II underscored not only personal vulnerability to horrendous stress, but also the protective power of the unit (community), and incentivized the government to step up efforts at treatment (Marlowe 2001). See also Chap. 36 on veterans issues. Until the middle of the twentieth century, however, the systems of care for those with serious mental illness evolved slowly, and little significant progress was made

toward actual treatment of mental illness; instead the major focus continued to be segregation of those with mental illness from the general public. However, the mid-1950s and early 1960s were the beginning of a massive transition of those with serious mental illness back into the community. Although the introduction of the discovery and use of major tranquilizers (chlorpromazine) has often been touted as the major influence in de-institutionalization (movement of state hospitalized patients into the community), it is entirely possible that finances and politics were major players as well. Grazier et al. (2005) noted:

> efforts to transfer responsibility/costs between and among agencies, states and the federal government, with persistent funding sources that were inadequate to meet the kind of resource and service needs of adults with serious mental illness… resulted in confusion, complexity in access to payment for services, created a burden on consumers and their families and disincentive from grass root providers to meet services needs…what developed was a lack of consistent national mental health policies…that led to a piecemeal financial system that diffused accountability, encouraged cost-shifting, and obscured service responsibility resulting in vulnerable populations being poorly served or abandoned (p. 549).

State and federal legislation was passed that moved the development of *community*-based systems of care forward. In 1948 the National Mental Health Act created the National Institutes of Mental Health with the goal of supporting and sustaining innovative mental healthcare programs and "scientific" treatment. In 1958, Congress passed the Mental Health Study Act, which was to "provide for an objective, thorough, and nationwide analysis and re-evaluation of the human and economic problems of mental illness" (Public Law 84-192). A resultant report (Action for Mental Health) delineated necessary funding, staffing, and treatment that President Kennedy used as a springboard to recommend a National Mental Health Program, calling for the building of 2,000 mental health centers to provide comprehensive community-based programs to serve those with severe mental illness, *and* adults, children, and families suffering from stress (Ewalt 1961). In 1963, the Mental Retardation Facilities and Community Mental Health Center Construction Act was signed into law; unfortunately, proposed funding for staff was revised downward in 1965, and only substantial funding for the building of community mental health centers remained. Still, these centers were to provide both inpatient and outpatient services, consultation and education, day treatment and crisis services. Centers serving rural areas and poor urban areas received additional funding. Worried that federal support would eventually disappear, there was some reluctance on the part of states to embrace these funds; by the time the program was terminated in 1981, only 754 catchment areas had applied for funding. In addition, many of those staffing mental health centers focused care on those who were not seriously mentally ill. "These times reflected the beginning of a philosophical shift in treatment; psychiatric predicated care fell to psychologists, and effective interventions were thought not be medical or biologic in nature, but to be social or educational, and where it was proffered, that early intervention could prevent mental illness" (Feldman 2010, p. 194).

The passage of Medicaid and Medicare in the mid-1960s offered some provision of care and service, although these programs were not designed for patients with serious mental illness. Without continuous employment, SSDI was not available to these patients, and lower payment and higher co-pays existed for mental health until recently. IMD (Institution for Mental Disease) restrictions kept (and still keep) patients with Medicaid from accessing free-standing psychiatric hospital services. Further elaborations on funding for mental health care are offered in Chap. 5 concerning behavioral health financing.

Eventually hospital closures and/or downsizing meant the state hospital populations went from a high of over 5,50,000 to 62,000 in 1996. In spite of promised assistance with treatment, medication, housing, and vocational training, during the 1970s and 1980s local mental health centers proved at best inconsistent in providing said treatment, and patients often found themselves facing "trans-institutionalization" (placement in nursing homes, boarding homes, foster care, jails or prisons).

While President Nixon was successful in withdrawing some public support of mental health

care, in 1977, President Carter empowered a Commission on Mental Health to review services and funding across the nation. It discovered that community services had increased over the last 15 years, but that substantial numbers of populations (ethnic minorities, the urban poor, women, children, veterans, those with physical handicaps, adults with chronic mental illness) were underserved, living without basic necessities, limited aftercare or medical care, and increased rates of hospital recidivism. The report encouraged the development of services for those with chronic mental illness, proposing federal grants for said development; the National Mental Health Service Systems Act of 1980 called for and funded a massive overhaul of the nation's mental healthcare system to focus priorities on services for these underserved populations. Unfortunately, it was underfunded by President Reagan and by 1981 deleted entirely by the Omnibus Budget Reconciliation Act, decimating years of federal leadership, serving to further dismantle the regional impact of NIMH, and reducing staff and services at local mental health centers. Criteria for SSDI also changed then; while patients with serious mental illness made up 11% of SSDI recipients, they were 30% of those who lost program eligibility (Feldman 2010).

The 1980s and 1990s were also decades of imposition of managed care on the service provision for mental health patients in the community. Capitation systems were put in place, ostensibly to maintain quality services while controlling costs. Standardization of assessments and treatment, limited enrollment rates, risk-sharing, and external regulation (all often predicated on minimization of hospitalization) placed enormous burdens on local MHCs. But "managed care, which fostered a system in which choice was limited, care was managed to decrease costs, and continuity was threatened, was particularly troublesome for individuals with socially stigmatized, poorly understood illnesses that had traditionally been treated separately from standard medical care" (Feldman 2010, p. 196). Many state systems of care funded by Medicaid were decimated, and equivocal results from this experiment continue to be reported.

Declared the decade of the Brain by President George HW Bush, the 1990s *did* reflect a revival in interest in biological treatment of serious mental illness, and ushered in a plethora of new medications, including the atypical antipsychotic medications, which were touted as being superior to older antipsychotic medication; they did seem to have a reduced (though still present) probability of causing tardive dyskinesia, a dramatic movement disorder side effect. However, as a class they also carried with them a propensity for placing patients at risk for weight gain, and development of diabetes, hyperlipidemia, and/or metabolic syndrome. While promising to enhance treatment, these new medications also imposed huge financial burdens on formulary costs, and "opened the door for massive influence by pharmaceutical companies" (Feldman 2010, p. 196). The Medicaid Rehabilitation option did encourage a focus on those with serious mental illness, and encouraged development of a broader array of services by offering payment for supports such as case managers, day treatment, and ACT (assertive community treatment teams). Many mental health centers utilized Medicare funding to provide partial hospitalization services in an attempt to minimize hospitalization and rehospitalization. It should be underscored that the focus of treatment during this time was on symptom control.

By the early 1990s, there were limited tool kits to guide clinical interventions, primitive evidence-based practices, few nuanced outcome measures, and an increasing demand for service in the face of an underdeveloped psychiatric workforce. In response, the federal government in 1992 directed NIMH to be reorganized under NIH (the National Institutes of Health) and CMHS (Center for Mental Health Services) to be moved under SAMHSA (Substance Abuse Mental Health Services Administration), which sought to encourage and support mental healthcare research and workforce development. The philosophy of a community supports system was embraced. Forays into vocational rehabilitation blossomed. Psychosocial and psychiatric rehabilitation models were developed by William Anthony and his colleagues which emphasized

the development of vocational rehabilitation plans; they focused on characteristics of work that were desired, the skills and knowledge necessary to perform the work successfully, the current level of readiness, and the methods to be used to help close the identified gaps (Wallace 1993; Lamb 1994; Liberman 1992). A wide variety of skills training, family psycho-education, and supported employment modules have been developed since then (see Chap. 25 covering supported employment). Barton (1999) reported that multiple programs focusing on empowerment, competency, and recovery had proven helpful: "the range of social, educational, occupational, behavioral and cognitive training has improved the role performance of persons with serious mental illness, and noted an average of 50% decrease in cost of care due to reduced hospitalizations" (p. 526).

The report of the U.S. Surgeon General in 1999 (U.S. Department of Health and Human Services 1999) denoted the gap between research and practice, and made recommendations "emphasizing a scientific base, overcoming stigma, public awareness, adequate services, cultural competence, and real parity" (Cohen et al. 2003, pp. 467–468). President Clinton's attempt at healthcare reform, which included parity between medical and mental health, proved unsuccessful. It was not until 2008 that Congress ultimately passed legislation requiring parity. More recently, tool kits and clinical guidelines have suggested evidence-based treatment interventions (APA practice guidelines), and since 2000 there has been increasing support for the development of means to assess efficacy of treatment and the push for evidence-based practice.

During the latter part of the 1990s and into 2000 and beyond, the major focus of treatment has shifted from symptom control to rehabilitation to recovery, "with the goal to help people pursue independence, self-management, personally meaningful activities and better quality of life" (Drake et al. 2003, p. 427). Core guidelines for recovery-oriented services included development of trusting consumer/professional partnerships less focused on hierarchy than on shared decision-making, psycho-education, relapse prevention, consumer-centered treatment planning, and strengths-based assessments. Involvement and engagement with families as collaborators has occurred. NAMI's use of family-to-family techniques has proven dramatically its efficacy. Addressing co-occurring disorders (substance use/abuse/dependence and medical illnesses concomitantly with mental illness) is proving challenging and yet without addressing these co-existing illnesses, patients will continue to be at higher risk for relapse and rehospitalization. Cognitive behavioral therapy, dialectical behavioral therapy, and peer support (utilization of consumers as peer specialists, bridge programs) have offered consumers innovative therapies that can enhance recovery. Community psychiatry has entered an era that seeks to endorse and support rehabilitation and recovery, often increasing the use of assertive community treatment teams to reinforce and support the skills sets necessary for recovery. Attention to the imperative issue of stable housing has moved to the forefront, with multiple models of housing (dry vs. damp vs. wet; housing first, transitional housing, permanent housing) being attempted.

Several salient court decisions have had a tremendous impact on the development of improved services for mental health patients. These are well summarized on a time-line in Chap. 6 on advocacy. Suffice it to say, each federal ruling underscores the movement along the spectrum of the right to receive the least restrictive treatment by those committed to the states for mental health care. Recent legislation continues to affect community psychiatry. The Medicare Modernization Act of 2005 proffered means by which those who had Medicare were able to purchase their medication, including psychiatric medication. In 2008 the Parity Act was passed that legislated that payment (and limits) for mental health and provision of mental health services (including substance abuse services) had to be essentially equivalent for medical and mental health care. Despite concerns that costs would rise precipitously, research reflects little impact on utilization, cost, or quality of care (Azzone et al. 2011). Healthcare reform, passed in 2010, offers a unique opportunity for the provision of mental health

care; however, ongoing challenges exist regarding the limitations of the mental healthcare workforce and the interface between mental health and primary care (please see Chap. 14 for detailed discussion).

In 2003, President George W. Bush assembled the New Freedom Commission on Mental Health. This group of healthcare practitioners was empowered to survey services across the United States, identifying programs that were particularly successful: "It reviewed the science of mental health, and mental health services, (and offered) an indictment of the mental health service system, which included fragmentation/gaps in care for children and adolescents, increased unemployment and disability (in those with SPMI) and noted that neither mental health nor suicide prevention was a national priority." Many examples of successful programs were highlighted. As detailed in Chap. 41, the commission recommended six general goals:

1. It must be understood that mental health is essential to overall health.
2. Mental health care should be consumer/family-driven.
3. Disparities had to be eliminated.
4. Early mental health screening assessments/referrals needed to be common.
5. Quality care should be delivered and research increased.
6. Enhanced use of technology (Grob and Goldman 2007).

Unfortunately, no monies were attached to the report or its recommendations, so the report's capacity to provide tangible influence to support evidence-based practice was limited. To its credit, the federal Center for Medicaid and Medicare Services embraced and promulgated a mantra of moving science into service, and has focused funding on that research which could do so.

As the first decade of the twenty-first century draws to a close, two salient forces are converging on the horizon: an increasing understanding that medications are not the be-all and end-all in the treatment of serious mental illness (Angell 2011); instead, it is now being embraced that medications can be effective but unless recovery-orientated services are established (funded and coordinated) and the consumer supported in the community, any success is fleeting. Stigma continues to hold powerful sway over law makers and common citizens, and financial systems (given the recession of 2008–2011) feel compelled to decrease funding for many things, including mental health. Perhaps the lives of those with mental illness can surmount the extant disparities to reach futures headed for recovery. These hopes are best summarized (though certainly not mandated or funded) by the President's New Freedom Commission (2003): "to achieve the promise of community living for everyone, new service delivery patterns and initiatives must ensure that every American has easy and consistent access to the most current treatment and best support services."

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Part II

The Basics: Central Pillars of Community Psychiatry

3 Epidemiology in Community Psychiatry

Dana March and Ezra S. Susser

Psychiatric epidemiology has played a central role in shaping the development of psychiatric care in the community over a period of 150 years. Signal developments in the evolution of community psychiatry emerged in tandem with psychiatric epidemiology in the mid-nineteenth century and again in the mid-twentieth century (Susser et al. 2010). In the current era, this close relationship continues, especially in the effort to "close the mental health gap," that is, give the same priority to mental as to other health conditions in national as well as global health initiatives.

In this chapter, we offer an introduction to two central topics in psychiatric epidemiology: (1) observational studies of incidence and prevalence, and (2) observational studies of causes. We omit key research areas that emerged from psychiatric epidemiology before branching out as partially separate disciplines that are still closely related to epidemiology: randomized clinical trials (especially preventive trials), mental health services research, and cross-cultural psychiatric research. For a more in-depth discussion and a wider range of topics, see this chapter's references (Susser et al. 2006; Tsuang et al. 2011; Thornicroft and Tansella 2009; Bhattacharya et al. 2010; Frank and Glied 2006).

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Incidence and Prevalence

It is useful to distinguish between two measures of disease/disorder occurrence, prevalence and incidence, as they serve distinct purposes for community psychiatry. *Prevalence* is the number of cases of disease or disorder in a given population at a particular time, or during a particular time frame. Prevalence includes both new and existing cases. Prevalence is useful to determine the burden of disease, and helps to determine the demand for care and services. *Incidence* is the occurrence of new cases of disease or disorder over a specified period of time in a given population. Thus incidence times duration is equal to prevalence. Incidence is expressed as a rate, reflecting the change in cases of disease over time. In community psychiatry, incidence is particularly useful in surveillance (i.e., is the number of new cases per year of autism on the rise in the United States?) for determining causes of disease (i.e., why is the number of new cases per year of autism on the rise? Is it because the distribution of some risk factor has shifted such that it is more common?). We discuss studies that use these measures of disease occurrence and their utility in depth below.

Prevalence of Common Mental Disorders

Cross-sectional studies that measured prevalence of common mental disorders in adults comprise a

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large swath of the observational epidemiologic studies informing community psychiatry. Such studies have for decades cataloged the burden of various mental disorders and thereby determining the need for services. In tandem, these studies often have examined patterns of service use, thus providing a critical epidemiologic frame for the distribution and provision of psychiatric care in the community. Such studies have both a fundamental utility and a rich history that has transcended shifting notions of what causes mental illness over time. This section of the chapter highlights the context, contributions, and limitations of key cross-sectional studies over time to community psychiatry, with special attention to the United States. These studies, which have been related integrally to public health policy, have established primarily that mental disorders are common and disabling, and that there is a need to reconcile gaps in service use with disorder burden.

The Burdens of Proof: The Midtown Manhattan and Stirling County Studies

Severe shortages in psychiatric services during World War II formed an advocacy platform for leading psychiatrists in the United States, and cemented the foundation for critical policy shifts in the postwar years. The community became the focus of renewed attention generated by the interplay between the field of psychiatry and policy makers in the United States. The National Mental Health Act of 1946 initiated a cascade of funding for psychiatric education and research that resulted in the establishment of the National Institute of Mental Health in 1949, and financial support for epidemiologic research in service of community psychiatry. Over the ensuing decades, an institutional and research context took shape in which the dynamic between community psychiatry and public policy would play out. Generations of key cross-sectional studies, which we examine here, were born of this marriage.

One of the earliest community-based cross-sectional studies conducted in the context of policy shifts and blossoming psychiatric research and education was the Midtown Manhattan Study (Srole et al. 1962). The purpose of the Midtown Study, initiated in 1952, was tripartite: to canvas the community for variations in mental health, to examine sociocultural determinants of mental health, and to establish the need for psychiatric services in the community. The Midtown study examined mental health in 1,660 adults culled from 1,911 Midtown dwellings, selected as a probability sample. All participants were white, ethnically heterogeneous, and similar in age and sex to the Midtown population, comprising approximately 100,000 adults.

The outcomes of Midtown were framed and defined in terms of health. Investigators, comprising psychiatrists and social scientists, devised a composite classification of mental health of the community's study participants, which they called the Global Judgment of Mental Health. This consisted of the following:

- Symptoms
- Freely associated elaborations (spontaneous or elicited)
- Interviewers' observations, reported descriptively and systematically in a prepared outline
- Data from a treatment census file of psychiatric care
- Results of a check by the New York City Social Service Exchange for family problems brought to attention of any city agency

One or more psychiatrists evaluated all of these components for each participant to arrive at an ecologically informed global judgment, which ranged from extremes of "symptom free" to "incapacitated," and included intermediate grades of symptom severity. Impairment in one or more areas of social functioning was chosen, according to the investigators, as the "arbitrary benchmark of morbidity" (Srole et al. 1962). By and large, the same ecological approach and set of methods employed by the Midtown Manhattan study were used by Alexander Leighton, himself a Midtown investigator, in the nonurban context of Stirling County, Nova Scotia. It reflected the recognition that the specificity of the context necessarily influenced the specific distribution of psychopathology—a hallmark of early epidemiologic studies informing community psychiatry. The Stirling County study also collected information on disorders as defined by the first

edition of the *Diagnostic and Statistical Manual* (DSM-I) (Leighton 1959; The Committee on Nomenclature and Statistics of the American Psychiatric Association 1952; Leighton et al. 1963a, b).

Importantly, because of the pitfalls of measuring lifetime disorders, Midtown and Stirling County investigators studied the point-prevalence of psychiatric morbidity, which would become a standard metric in the major psychiatric epidemiologic studies that would follow. Over 80% of those surveyed, chosen to reflect the ethnic heterogeneity of Midtown, had some form of psychopathology. About a quarter (23.4%) were classified as impaired, signifying the presence of marked, severe, or incapacitating symptoms—mostly anxiety. Moreover, about three quarters of those who were impaired had never sought help for their symptoms (Srole et al. 1962). In Stirling County, lifetime prevalence of any DSM-I mental disorder was about 57%; point prevalence was estimated at 90% of the lifetime prevalence. Like Midtown, significant impairment was found in about 24% of participants (Leighton 1959; Leighton et al. 1963a, b).

Most in the scientific community found these rates shocking. However, the Midtown and Stirling County investigators believed the results were reasonable, given the composition and context of the community. Despite social status, members of these communities were burdened with a range of mental problems, and the availability of mental health services was, quite simply, inadequate.

The Proof of Burden: The Next Generation of Epidemiologic Studies

As controversial as they were, the results of these key studies highlighted important differences from previous studies, such as the Baltimore Morbidity Study (Commission on Chronic Illness 1957), which found rates of mental disorder in the community to be about half that of the Midtown Manhattan and Stirling County Studies, and set the stage for increasingly sophisticated contemporary psychiatric epidemiology studies. In conjunction with major advances in diagnostic criteria and nomenclature, the 1961 Joint Commission on Mental Illness and Health and a cascade of other shifts that prioritized systematic data collection in service of community psychiatry gave rise to a new era of community-based epidemiologic studies.

The Epidemiologic Catchment Area Study

The Epidemiologic Catchment Area (ECA) study was a signal study of this new era. The ECA was initiated in response to the 1977 Report of the President's Commission on Mental Health, which described the state of American mental health research and services (Grob 2005). NIMH needed to provide descriptive psychiatric epidemiologic data to the President's Commission, since the clinical picture of community mental health was incomplete (Regier et al. 1978; Robins 1978). The ECA, therefore, sought to address the gaps identified in the President's Commission report (Robins and Regier 1991).

The ECA, which commenced in 1980, was a collaborative effort between NIMH and a group of established psychiatric epidemiologists that surveyed the prevalence of mental disorders and service need and use in five US communities that had been designated Community Mental Health Center catchment areas—Baltimore, New Haven, St. Louis, Durham, and Los Angeles. Each site collected data on a common set of core questions and sample characteristics, and sampled over 3,000 community residents and 500 institutionalized residents. Together, the 5-site ECA collected diagnostic and service need and use data on 20,861 adults, aged 18 and over. The ECA used the lay-administered NIMH Diagnostic Interview Schedule (DIS), Version III and the newly issued Third edition of the DSM (American Psychiatric Association 1980) for diagnostic classification (Robins and Regier 1991). The ECA was the first study to document the prevalence of DSM-III disorders. While the ECA determined the epidemiologic burden and service use patterns in these five communities, it also provided the indices of success of community-based treatment programs for mental illness.

Overall, the ECA found a somewhat similar burden of mental illness documented by the Midtown Manhattan and Stirling County

Table 3.1 Prevalence estimates from contemporary psychiatric epidemiology surveys

	Study%			
	Epidemiologic catchment area (ECA)	National comorbidity survey (NCS)	NCS replication (NCS-R)	World mental health surveys
Mood disorders				
12-month	3.7	11.3	9.5	0.8–19.6
Lifetime	7.8	19.3	20.8	3.3–21.4
Anxiety disorders				
12-month	18.1	17.2	18.1	2.4–18.2
Lifetime	28.8	24.9	28.8	4.8–31.0
Psychotic disorders				
12-month		0.5	–	–
Lifetime	1.4	0.7	–	–

studies; lifetime diagnoses of anxiety disorders were reported in nearly a third of respondents, compared to mood disorders in about 8% (Table 3.1).

The ECA was critical in determining the prevalence of specific psychiatric disorders, as well as service needs and use patterns in the five communities studied. The rich information provided by the study once again supported the notion that services were inadequate relative to need; under 20% of respondents with recent mental disorders accessed services in the year prior to study participation (Robins and Regier 1991; Regier et al. 1993). However, because the samples in the ECA were not collected to be nationally representative, there was an imperative to address epidemiologic gaps regarding the prevalence and distribution of psychiatric disorders in the United States. Moreover, the ECA could only provide basic information regarding the comorbidity of psychiatric disorders; it was, therefore, necessary to determine patterns of comorbidity and the complexities of the affiliated need for and use of services.

The National Comorbidity Surveys and the Collaborative Psychiatric Epidemiology Surveys

Some of the limitations of the ECA influenced deeply the National Comorbidity Survey (NCS), a study of the prevalence, causes, and consequences of comorbidity between psychiatric and substance use disorders (Kessler 1994). The NCS, which began in 1990, was the first survey of mental and substance use disorders in the United States to use a completely structured diagnostic interview, the Composite International Diagnostic Interview (CIDI), to determine the prevalence and correlates of DSM-III-R disorders in a nationally representative sample of 8,098 individuals, aged 18–54. The prevalence estimates of lay-administered CIDI-diagnosed psychiatric disorders were higher than those reported by the ECA, with the exception of psychotic disorders and lifetime anxiety disorders (Table 3.1). Almost half of those surveyed reported at least one lifetime disorder, and about 30% endorsed a psychiatric disorder within the past year. Notably, over 50% of all lifetime disorders occurred in a small proportion of the respondents with a history of three or more comorbid disorders (Kessler et al. 1994). Like the ECA, the NCS reported underuse of mental health services—about 13% of respondents accessed outpatient services in the prior 12 months. One of the most striking findings of the NCS indicated a problem with "met unneed"—that is, people with low levels of need had a higher probability of accessing treatment (Kessler et al. 1997; Mojtabai et al. 2002), with implications for policies affecting the distribution of community-based mental health services.

Similar prevalences of DSM-IV (American Psychiatric Association 1994) disorders and

service use patterns were observed in the NCS Replication (NCS-R), conducted about a decade later in a nationally representative sample of 9,282 respondents, aged 18–54 (Table 3.1) (Kessler et al. 2005a, b). Harkening to the results of the Midtown Manhattan Study, 26.2% of respondents reported a past-year psychiatric disorder; nearly a quarter those with a past-year psychiatric disorder were classified as serious (Kessler et al. 2005b). As in the NCS, comorbidity was common; nearly 30% of the people surveyed had two disorders, and almost 20% had three (Kessler et al. 2005a, b). Likewise, significant unmet need for services was observed in the NCS-R; nearly 60% of those endorsing a past-year psychiatric disorder remained untreated. Racial/ethnic minorities, low SES individuals, elderly persons, the uninsured, and rural residents were least likely to receive services (Wang et al. 2005). Apropos of now current policy initiatives that encourage the integration of primary and behavioral health care, among those who accessed services, the greatest utilization occurred in general medical settings, although those accessing specialty providers for treatment had more visits and were more likely to have received minimally adequate care (Wang et al. 2005). Moreover, the "met unneed" assessed originally in the NCS showed that the bulk of services for psychiatric or substance use problems are delivered to people with indicators of need, including past year diagnoses, and that those without indicators of need are in care delivered outside of the formal health care system (Druss et al. 2007).

Along with the NCS-R, two other cross-sectional studies examining the prevalence and correlates of psychiatric disorders and rates of service utilization among specific racial/ethnic groups in the United States—the National Survey of American Life (NSAL) and the National Latino and Asian American Study (NLAAS)—comprised the Collaborative Psychiatric Epidemiology Surveys (CPES). Together, these studies indicate that the prevalence of common mental disorders is higher in non-Hispanic white Americans than in other racial/ethnic groups except Puerto Ricans (Kessler et al. 2005a, b; Alegria et al. 2007; Williams et al. 2007), although this has been the subject of much debate. Critically, despite a purported lower prevalence of common mental disorders among most racial/ethnic minority groups, the course of disorder is more chronic, disabling, and more likely to remain untreated (Miranda et al. 2008).

In the United States, therefore, community psychiatry faces particular and historically enduring challenges of meeting the complex needs of those with psychiatric disorders, especially those that are more common. The burden of common mental illness, and the relative lack of services for those most in need, has been well documented, with increasing diagnostic precision and methodological advances—albeit not without growing pains—over the postwar decades. The "proof" of the burden of mental illness demonstrated by cross-sectional epidemiologic studies carries with it directives to those responsible for shaping policies allocating the requisite resources for community psychiatry. Unfortunately, the response is somewhat diffuse and intractable, underscoring the need for continued and expanded advocacy in this arena.

World Mental Health Surveys

Efforts to determine the burden of mental illness in communities across the world have been plagued by diagnostic difficulties; specifically, cross-national studies prior to the ECA and NCS eras lacked a common format. Structured diagnostic instruments facilitated the conduct of large psychiatric epidemiology surveys across settings. In the 1980s and the 1990s, cross-national epidemiologic surveys were conducted using the DIS (as in the ECA) and the CIDI (as in the NCS and NCS-R). However, while these instruments provided a means of obtaining comparable prevalence estimates, they did not assess adequately severity, impairment, or treatment. Thus, in 1998, the World Health Organization established the World Mental Health (WMH) Survey Consortium in 1998 to create a diagnostic instrument that would fill these gaps (The WHO World Mental Health Survey Consortium 2004). After extensive cross-national piloting, the WHO CIDI was ready for use (The WHO World Mental Health Survey Consortium 2004).

The WMH surveys, which spanned 14 countries ranging in development status, were based on the NCA model. Face-to-face community interviews were conducted with 60,343 adults. The WMH surveys estimated the prevalence of mental disorders worldwide to be approximately 30% (The WHO World Mental Health Survey Consortium 2004). Moreover, mental disorders account for nearly 40% of healthy years lost from disease, and are the leading cause of disability worldwide, even in low and middle income countries, where the burden of other communicable and noncommunicable diseases is substantially greater than in high income countries (Wang et al. 2007).

Consistent with surveys in the United States, anxiety and depressive disorders were the most common across the 14 countries. However, the WMH surveys indicate wide variation in the lifetime and 12-month prevalence of disorder (Table 3.1). The lowest rates of anxiety were found in Shanghai, with 2.4% of respondents meeting criteria for an anxiety disorder over the past year to 18% in the United States. For mood—mainly depressive—disorders, Nigeria had the lowest 12-month rates, with less than 1%. Once again, the United States had the highest rates of past-year mood disorders, affecting nearly 10% of the sample (The WHO World Mental Health Survey Consortium 2004).

In terms of severity, mild disorders comprised the bulk of 12-month cases, ranging from 33.1% of cases in Colombia to and 80.9% of cases in Nigeria. Significant role impairment was affiliated with serious mental disorders. With respect to treatment, between one third and one half of those with serious mental disorders in developed countries did not receive treatment, compared to over three quarters in developing countries. Overall, while severity was related to likelihood of treatment in the majority of countries, there are clearly inadequate mental health services relative to the demand; treatment resources in every country were devoted to mild mental illness, leaving those with serious mental illness in communities across the world without resources. This distribution of resources might be addressed with redistribution policies aimed at treating more severe illness (The WHO World Mental Health Survey Consortium 2004).

Limitations of Cross-Sectional Studies of Common Mental Disorders

As mentioned previously, while the strengths of cross-sectional studies have been extremely useful, especially for informing community psychiatric care, it is important to keep in mind their limitations. First, cross-sectional studies are restricted in their ability to identify causes. That is because cross-sectional studies are unable to establish temporality, or the temporal ordering of exposure and outcome. It is also because prevalence, the metric of burden established by cross-sectional studies, reflects both incidence, or the occurrence of new cases over a given period of time, and duration of illness (Susser et al. 2006). Second, with few exceptions (Phillips et al. 2009), these studies only provide good estimates of common disorders, and have not proved useful for studying the prevalence of severe but less common disorders such as schizophrenia. Third, they have focused largely on young and middle aged adults, leaving a gap for information on mental disorders in childhood and later life. Fourth, faced with limited resources and the need to apply the same procedures across settings, they have in general they have not given sufficient attention to cross-cultural differences in the expression and measurement of mental disorders, although there are some exceptions (Kim et al. 2011). Finally, these cross-sectional studies perform much better for estimates of current prevalence (whether the individual had the disorder over past 3 or 12 months) than for estimates of lifetime prevalence (whether the individual ever had the disorder) (Susser and Shrout 2009). In public and policy forums, however, the far less reliable lifetime prevalences tend to be used; when it is necessary to make sweeping statements about needs and services to policymakers and the public, lifetime prevalences are elusively simple, and more likely to engage the audience.

Incidence Studies

For severe mental disorders that often persist over a long period, such as schizophrenia, incidence studies have provided more information than cross-sectional community surveys. We use

examples of incidence studies of schizophrenia, where incidence studies have provided vital information on the occurrence of disease across time and place, and thereby have provided key information regarding paths to understand causes (see next section).

In the 1960s, the International Pilot Study of Schizophrenia (IPSS), sponsored by the WHO, set out to determine if it was feasible to engage in large scale epidemiologic research of psychiatric disorders, specifically schizophrenia, with comparable methods across different contexts, and to determine what, if any differences existed in the incidence of schizophrenia across contexts (Sartorius et al. 1974). Indeed, the IPSS, which included 1,202 participants in its initial assessment, showed that this type of study was feasible. The IPSS also demonstrated that what schizophrenia was, both broadly and narrowly defined as a construct with extensively tested instruments, was fairly consistent across contexts (Sartorius et al. 1974).

Later, the WHO sponsored the Determinants of Severe Mental Disorders (DOSMeD), also known as the Ten Country Study, which built on the work of the IPSS to study the variation in incidence and course of severe mental illness, particularly schizophrenia, across countries and cultures. The DOSMeD included sites in Denmark, India, Colombia, Ireland, the United States, Nigeria, the USSR, Japan, the United Kingdom, and the Czech Republic. The DOSMeD, which studied mental health catchment treatment areas, found that narrowly defined schizophrenia arose at about the same rate across the countries; more broadly defined schizophrenia was far more variable, ranging from 1.5 to 4.2 per 100,000 persons aged 15–54. In addition, the DOSMeD showed a better course of schizophrenia in developing vs. developed countries over a period of 2 years (Jablensky et al. 1992), which gave rise to a long debate over the potential factual and artifactual explanations (Hopper and Wanderling 2000). More recent evidence shows that incidence does not vary by country's economic status (Saha et al. 2006). In addition, a 2008 analysis of the WHO data by Cohen and colleagues (Cohen et al. 2008) indicates that the prognosis of schizophrenia is not actually better in developing countries. There appears to be a complex of circumstances—for example, heterogeneity of clinical outcomes across settings (McGrath 2008), interactions among contextual, individual, and biological factors (Strauss 2008), and the intraethnic and intrasocietal diversity that shapes the social processes influencing conceptualizations of both illness and course (Kleinman 2008)—that have influenced the shifting notions in this much-contested arena.

As demonstrated by the IPSS and WHO Ten Country Study, incidence studies across contexts can show uniformity in rates of a given outcome—here, schizophrenia. When they show variation across a given dimension, such as time, place, or population, what is responsible for that variation can be studied. A recent meta-analysis by McGrath shows considerable variation in schizophrenia across population and context (McGrath et al. 2004). Some of the most interesting studies of schizophrenia incidence, which integrate both population and context, are the studies of migrants. Elevated rates of schizophrenia have been shown among migrants since the 1930s (Ødegaard 1932; Cantor-Graae and Selten 2005; Kirkbride et al. 2006; Veling et al. 2006). More recent studies of schizophrenia incidence have examined rates in migrants to Holland in a first-contact study in The Hague compared to those in the native Dutch (Veling et al. 2006), and a study of schizophrenia rates in African Caribbean migrants compared to native British in Southeast London (Kirkbride et al. 2006). Rates are considerably higher among migrants in these studies. That variation of incidence rates exists among these populations indicates that a potential social mechanism is at play. For instance, discrimination has been shown to be related to elevated rates among migrants in The Hague (Veling et al. 2006). In addition, other community-level factors, such as social fragmentation, have been shown to be related to the elevated rates among African Caribbean people in Southeast London (Kirkbride et al. 2006). Other studies have examined race/ethnicity pursuant to these findings, and have found, for example, variation between blacks and whites in the United States (Bresnahan et al. 2007). Some of the most compelling

avenues to pursue involve studying the cascades of social factors that may produce variation in rates of schizophrenia across place and population (March et al. 2008). Upstream social factors, such as poverty or structural discrimination, are by themselves insufficient to cause disease or disorder. However, these upstream risk factors either shape or work in conjunction with other, risk factors more proximate to the individual that accumulate to produce illness (Susser et al. 2006). By studying these multilevel factors, we can work to identify multiple levers of intervention for illnesses like schizophrenia.

While incidence studies can help to address some of the limitations of prevalence studies and can permit the examination of underlying causes, should variation exist, they also have limitations. For example, incidence studies are often first-contact studies, or studies that rely necessarily on the incident cases presenting to services for ascertainment. Therefore, in contexts that do not have coordinated or linked health service records, incidence studies prove quite challenging. Increasingly, psychiatric registries are used to determine incidence rates in given populations (e.g., Denmark, Sweden, and Finland), although these also have similar limitations because they require cases to present to services.

Observational Studies of Causes

Natural Experiments

Natural experiments constitute the strongest observational design. Natural experiments capitalize on external circumstances (whether naturally occurring, or on some level, human-made) that select people into groups that are exposed or unexposed to a risk factor for disease in order to study causes. In natural experiments, the population under study has little or no control over the circumstances that render them either exposed or unexposed to a risk factor or set of risk factors for a particular outcome of interest. Because people often have the ability to shape their exposure to a given set of risk factors for disease (e.g., individual dietary and physical activity choices, smoking habits, etc.), and because those choices are often linked (e.g., people who eat high-fat foods tend to exercise less), those who are exposed or unexposed to a particular risk factor are likely to differ on many other factors that may influence a particular outcome of interest. That is, the association between exposure and outcome may be confounded by other factors that are related to both the exposure and the outcome. Isolating the effect of the cause, therefore, may prove difficult. Natural experiments, however, help to isolate the causal effect of the risk factor of interest by removing from consideration other factors that may influence the association between exposure and outcome (Susser et al. 2006).

Many examples of natural experiments exist (Susser et al. 2006), but we focus on two instances that help elucidate the association between prenatal exposure to famine and adult schizophrenia here. The first natural experiment we highlight here is the Dutch Famine Study, a study of prenatal exposure to famine in Holland during the Dutch Hunger Winter of 1944–1945. A Nazi blockade of Western Holland at the end of World War II gave rise to a severe famine that had a clear beginning and end in a particular location. In the cities that experienced the famine, the birth cohort in gestation during the famine period was nutritionally deficient during gestation. Birth cohorts before and after the Nazi blockade were not nutritionally deficient during gestation, and neither were the birth cohorts in cities that were not subject to the Nazi blockade. Rates of schizophrenia during adulthood were twice as high among the birth cohorts exposed to prenatal nutritional deficiency than those that were not (Susser et al. 2006; Susser and Lin 1992).

Another natural experiment in China obtained similar results. During the Great Leap Forward in China in the 1950s and 1960s, the collectivization of agriculture, adoption of poor agricultural practices, and reduction of cultivated land contributed to a famine that affected the entire country. However, certain provinces in China were more profoundly affected than others. Anhui province was one of the most severely affected. By the spring of 1959, people in Anhui were starving and began dying in masses. In early

1961, the famine had receded, whereas it continued in other provinces in China throughout the year—circumstances that were beyond the control of those exposed or unexposed. As in the Dutch Famine Study, researchers capitalized on this natural experiment to examine the rates of adult schizophrenia among those exposed to famine in utero. And, as in the Dutch Famine Study, rates of schizophrenia were twice as high among the people in provinces exposed to famine during gestation as those who were not exposed to famine during gestation (St Clair et al. 2005). Both studies provided robust evidence in the context of a string design consisting of naturally occurring (albeit man-made) experiments indicating that prenatal nutritional deficiency was associated with increased risk of schizophrenia during adulthood.

Cohort Studies

Cohort studies, which are longitudinal observational studies of subjects with a shared characteristic (e.g., birth date) or experience (e.g., military service), can grapple with the issue of temporality and distinguish between cause and effect. In the previous section, we emphasized cross-sectional studies with an emphasis on the United States. In our discussion of the contribution of cohort studies to community psychiatry, we shall emphasize primarily investigations from the United Kingdom.

One of the most notable cohort studies with real relevance to community psychiatry is the British 1946 birth cohort study, known formally as the National Survey of Health and Development (NSHD). This particular study is the oldest—now in its 65th year (Pearson 2011)—among the British birth cohort studies, which include samples from 1946 (Wadsworth et al. 2006), 1958 (Power and Elliott 2006), 1970 (Elliott and Shepherd 2006), and 2000 (Parkinson et al. 2011), and the longest ongoing birth cohort study in the world (Medical Research Council 2011), as well as a model for numerous other cohort studies. The NSHD comprises a cohort of 5,362 children born in the England, Scotland, and Wales in the same week of March 1946, which has been assessed 22 times to date. The cohort members were culled from an original sample of 13,867 children born to 91% of all British mothers giving birth during the weeklong time frame. Like the cross-sectional studies described in the previous section, the NSHD was initiated in response to a set of social contextual concerns—poverty, employment, housing, declining birth rates, and health—and in service of shaping policies that might make a difference in the health and lives of a generation coming up in a dramatically changed postwar Britain (Medical Research Council 2011).

The architect of the study, physician James Douglas, wove an interest in mental health and well being into the study, undertaken originally to examine the quality of maternity services across social class, very early on. As a result, cohort assessments during childhood included maternal and teacher questions regarding children's behavior and mental well-being. Over the course of the entire study, during some childhood assessments and all assessments during adulthood, cohort members have been surveyed on their thoughts and emotions (Medical Research Council 2011) using a variety of validated instruments for surveying symptoms of mental disorders. With implications for prevention, assessments of cognitive functioning and aspects of physical health, the NSHD offers a trove of epidemiological information regarding how these illnesses unfold over time together with the types of exposures that are particularly important.

The NSHD has provided some key information regarding mental health over the life course, including early determinants of mental health, the course of mental disorders over the life span, the role of reproductive issues in the mental health of women, and treatment use.

In the area of early determinants of mental health, the NSHD has contributed key knowledge. For example, the NSHD has shown that the effects of parenting persist into mid-adulthood. In one study the effects of parenting on the psychological well-being, 984 women were assessed; extraversion and neuroticism was assessed at age 26, parental practices were recollected at age 43, and

psychological well-being was assessed at age 52. Higher levels of parental care were associated with higher psychological well-being, while higher parental nonengagement or control was associated with lower levels of well-being. Care and nonengagement were mediated by offspring personality, while control had direct effects on well-being. Psychological well-being was at least as strongly linked to fathers as to mothers parenting style (Huppert et al. 2010). In another study of the persistent effects of parenting, the NSHD showed the negative impact of parental separation on the mental health of cohort members (Huppert et al. 2010; Richards and Wadsworth 1997).

The NSHD has also informed our understanding of the course of mental disorders over the life span. From the NSHD, we know that mental problems in childhood carry into adulthood (Colman et al. 2007), that stress and milder common mental health problems appear and disappear over the life course (Hatch et al. 2009), and that positive well-being can persist across the life course (Abbott et al. 2008; Richards and Huppert 2011). The NSHD has also shown that mental health has consequences for physical health and mortality (Gaysina et al. 2011). Finally, the NSHD has shown the public health significance of conduct disorders over the life course. Cohort members ($n=3{,}652$) were assessed by teachers for externalizing behavioral symptoms at ages 13 and 15. Outcomes were mental disorder, alcohol abuse, relationship difficulties, highest level of education, social class, unemployment, and financial difficulties at ages 36–53. Cohort members with severe ($n=348$) and mild ($n=1{,}051$) externalizing behavior problems were compared to those judged to have no externalizing behavior problems ($n=2{,}253$). Mild and severe externalizing behavior problems predicted school dropout (Colman et al. 2009).

The relative importance of stressors over the life course on common mental disorders was demonstrated by the NSHD, which showed that among 2,073 cohort members, stress is an important antecedent of common mental disorder from early to mid-adulthood, but not as important, perhaps, as those that contribute to a notable life change 36, 43, and 53 years (Hatch et al. 2009). In addition, reproductive issues have been examined in the NSHD. Findings suggest that early motherhood (prior to age 21) related to poorer mental health at age 53 (Henretta et al. 2008), and moreover that women who undergo hysterectomies, particularly for cancer, or before age 40, have poorer psychological health than those who had not undergone hysterectomies (Cooper et al. 2009).

The NSHD has also informed important long-term treatment questions. For example, the NSHD has provided data on the long-term treatment with antidepressants and anxiolytics. In one study, depression and anxiety symptoms were assessed at age 43; among the 157 with a mental disorder, those using medications were compared to those who were not on psych outcomes at age 53. Use of medications at 43 was associated with lower prevalence of psychiatric disorder at age 53, and only a quarter were still taking medications at age 53 (Colman et al. 2008b). Another study assessed the correlates of antidepressant, anxiolytic, and hypnotic use between ages 36 and 53. After adjusting for severity of symptoms of depression and anxiety, clinical factors (e.g., suicidal ideation, sleep difficulty, and poor physical health) were strongly associated with antidepressant, anxiolytic, or hypnotic medication use in 1982 and 1989, but not in 1999. Nonclinical factors were infrequently associated with antidepressant, anxiolytic, or hypnotic medication use in 1982 and 1989 after adjusting for severity of symptoms, however several nonclinical factors were associated with antidepressant, anxiolytic, or hypnotic medication use in 1999 including being female, living alone, and being divorced, separated, or widowed (Colman et al. 2008a).

Strengths and Limitations of Cohort Studies

Perhaps the most notable strength, cohort studies permit an assessment of a causal relation between exposure and outcome, because they satisfy the hallmark criterion for causality—that the exposure precedes the outcome. Cohort studies also permit the examination of the relations among a variety of exposures and outcomes, as they unfold

over the life course. The major drawbacks to cohort studies are the investments required, in terms of financial and temporal commitments. Two factors underlying the marked success of the NSHD, for example, are the virtually continuous stream of funding, and the continuity of investigators and research personnel.

Case–Control Studies

Case–control studies, which examine exposure to a given risk factor of interest among predefined outcome groups (e.g., one with the disorder of interest, and one without), can be used to answer a question more efficiently than a cohort study, particularly for outcomes that occur in less than 10% of the population. The efficiency offered by a case–control study outweighs the potential for bias, although steps can be taken to minimize bias. There are also many other advantages and disadvantages to the use of each of these designs, elaborated elsewhere (Susser et al. 2006; Rothman et al. 2008).

One way to conceptualize a case–control study is as an efficient way of sampling an underlying cohort of exposed and unexposed people, some of whom develop the disease of interest (Susser et al. 2006; Rothman et al. 2008). This is most clearly seen in the context of a *nested* case–control study where the underlying cohort is enumerated, but the same logic applies to all case–control studies. The goal of a case–control study is to obtain the result that one would have obtained in a perfect cohort study, but using far fewer respondents. The validity of the case–control study depends on two critical steps: selecting controls from the same source population that gave rise to the cases and selecting controls independent of exposure status. When these two principles are applied, the controls will represent the ratio of exposed to unexposed in the population from which the cases were derived.

Under these conditions, other things being equal (e.g., control of confounding, validity of exposure data), the odds of exposure for cases vs. noncases (exposure odds ratio from a case–control study) is equal to the odds of disease for exposed vs. unexposed (disease odds ratio from a cohort study based in the same source population). This equality of the exposure odds ratio in a case–control study and the disease odds ratio in the underlying cohort can be demonstrated algebraically. Thus, the relation of exposure to disease, in the form of an odds ratio, can be obtained from a case–control study. In a nested case–control study, when the underlying cohort can be fully enumerated, one can select controls from the source population (i.e., the underlying cohort) independent of exposure status, and thereby obtain the same odds ratio in a case–control study as one would have obtained in a cohort study, but at much less cost and in a much shorter time.

The majority of case–control studies, however, are not nested in a fully enumerated cohort. One has to conceptualize and then sample the source population that gave rise to the cases. This introduces potential for bias, because there is generally some uncertainty about the source population and the best approach to sample it. In many though not all scenarios, this potential bias can be minimized by a thoughtful design, and case–control studies will produce valid results. Similar to cohort studies, there are numerous variations of the case–control design, but they are all based on the premise that the (exposure) odds ratio from the case–control study will approximate the (disease) odds ratio that would have been obtained from a cohort study of the source population.

Here, we use the example of a case–control study that examined the contribution of heavy alcohol use to the increase in adult mortality rates in Russia in the 1990s (Zaridze et al. 2009). By the year 2000, in Russia, the probability that a 15-year old man would die before age 35 was 10% and that a 35-year-old man would die before age 55 was 27%; in Western Europe, these probabilities were only 2 and 6% respectively (Zaridze et al. 2009). This reflected a dramatic increase in mortality that was unprecedented for an industrialized society, except in the context of war.

Prior to this study, it was known that both alcohol use and mortality had increased sharply following the collapse of communism in 1991,

peaking in 1994. This suggested two possible explanations. The first was that social upheaval led to increased alcohol use and thereby increased mortality. The second was that social upheaval confounded the association—that is, it led to both increased alcohol use and increased mortality and created a noncausal association between them. Previous research had suggested that alcohol consumption and mortality patterns were likely to be causally related (Leon et al. 1997, 2007), but the question remained unresolved.

The investigators studied three industrial cities in western Siberia with 2002 census populations of 0.5, 0.7, and 0.2 million and principally European Russian populations. In these cities, both the overall mortality rates and the distribution of certified causes of death were similar to those in the whole of Russia, and fluctuated in a similar way, with a sudden large increase in mortality from 1992 to 1994 (Men et al. 2003).

The cases and controls were selected from 200,000 residents of these three cities who died age 15–74 years between 1990 and 2001. Local records included all deaths among registered residents, but not migrants. In addition to name, age, sex, and cause of death, the address of the deceased was recorded on death records. The investigators chose to study deaths in neighborhoods in which they were most likely to obtain high participation rates. The teams of interviewers were familiar with the neighborhood and known to many of the residents. The total number of deceased persons included in the investigation was 60,416.

The deceased persons were classified as either cases or controls according to the cause of death. Since the recorded causes of death did not conform to ICD classifications, these codings were ignored and ICD-10 was used to assign underlying causes from death certificates. Cases were defined as persons who died from causes suspected beforehand to be related to alcohol or tobacco. They were the vast majority. Controls were persons who died from any other cause.

The investigators culled information about alcohol use by the deceased by visiting their addresses in death records and conducting proxy interviews with family members. Sufficient information was obtained for 48,557 deceased persons, among whom 43,082 were cases and 5,475 were controls. Since proxy information from the family is necessarily imperfect, and vulnerable to recall bias, the investigators built in procedures to improve accuracy and reduce bias. For example, the interviewers did not know the cause of death of the deceased and were therefore blind to case vs. control status. Also, the interview covered mainly other topics so that questions about alcohol use were unobtrusive. Interviewers were carefully trained and supervised and 10% of interviews were randomly chosen for repetition to monitor performance.

The questionnaire asked about usual weekly alcohol consumption patterns before and during the final year of life. The responses for these two time periods tended to be similar, and the greater of the two was used. Total weekly consumption of any kind of alcohol was converted to equivalents of 500 mL bottles of vodka. There were three exposed drinking groups: less than one bottle per week, one to less than three bottles per week, and three or more bottles per week.

We call attention to three key results of this study. First, the authors found extremely strong and dose-related associations between heavy alcohol use and deaths suspected to be alcohol-or tobacco-related (the great majority of deaths, see above). The associations were strongest for those more likely to be related to alcohol than tobacco (e.g., alcohol poisoning and accidents). The investigators examined and tried to quantify potential bias in their results, and concluded that the potential for bias was small in relation to the large size of the effects they detected. They inferred that there was a causal relation between heavy alcohol use and mortality. Further, they estimated that alcohol was responsible for about one half of deaths among men and one quarter of deaths among women in the age group 35–54, and was also a major cause of death among men and women in the age group 55–74.

Second, the largest contributors to alcohol associated excess mortality were accidents and violence. The relative risks for death from assault and suicide were greatest in the highest male and the two highest female alcohol consumption

categories. Thus, it appeared that a very large proportion of the excess deaths were related to the effects of alcohol on behavior. This suggests that public health practitioners need to be concerned with not only the physical effects of heavy alcohol use on the body (e.g., cirrhosis), but also (or perhaps more), with its mental effects on hazardous behaviors. In Russia, not only interventions that reduce alcohol consumption but also interventions that reduce the hazardous behaviors associated with alcohol consumption are required for reducing the high mortality rates. This is no doubt also true, to some degree, for many other nations.

Third, after their case–control data suggested that the association between heavy alcohol use and mortality was likely to be causal, the authors turned to another approach to help rule out alternative explanations. They examined the ecological relationship between alcohol use and mortality in the 1980s in Russia, the period prior to the social upheaval that accompanied the collapse of communism. They showed that between 1985 and 1987, following a short-lived 1985 restriction placed on alcohol use under the Gorbachev regime, both alcohol use and mortality declined suddenly and sharply. This suggested that other effects of the social upheaval of 1991 were less viable explanations for the increased mortality of the 1990s, and supported the view that increased mortality was mediated by increased alcohol consumption, as suggested by their case–control study. This finding is also remarkable for the closeness in timing of the fluctuations in alcohol use and mortality, again suggesting that immediate behavioral effects of alcohol mediated much of the relationship to mortality. It provides an informative contrast with cigarette smoking, for which mortality is mainly related to long-term effects on disease risk later in life.

Conclusion

In this chapter, we have covered epidemiological terrain with particular relevance to community psychiatry. We have focused and anchored historically our discussion on two key areas: observational studies of incidence and prevalence, and observational studies of causes. In examining first observational studies of incidence and prevalence, we have provided basic information on the measures of disease occurrence and their practical uses. We have sketched the epidemiology of mental disorders in the United States through select surveys, presented the key results of an important cross-national survey, and addressed their implications for public policy and the allocation of resources for prevention and treatment.

In subsequent discussions of observational studies of causes, we have covered in depth natural experiments, cohort studies, and case–control studies by use of examples that highlight the connection between epidemiology and community psychiatry and indicate how useful methodologically sound epidemiologic studies can be for the purposes of undertaking studies of causes in the broad range of outcomes with which community psychiatry concerns itself.

In closing, epidemiology and its armamentarium of methods provide a set of tools that can be put to good use in community psychiatry. Epidemiology helps provide an evidence base for community psychiatry, with an eye, ultimately, toward intervention. Indeed, epidemiologic studies have contributed much to the evidence-based policy-makers leverage to allocate funding for interventions, services, models of treatment provision, and directions in what treatments work best for people in a given set of circumstances. It is simply up to community psychiatry to determine what future uses they may most fruitfully apply the suite of methods that may serve it and the people it serves the best.

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4 Public Health, Prevention, and Community Psychiatry

Michael T. Compton

Introduction

Community psychiatrists have traditionally approached their work from diverse perspectives. Although the biopsychosocial model is more consistent with this approach than the more widely practiced medical model, the public health model—focusing on entire communities and populations—is also consistent with the eclectic values and practices of the field of community psychiatry. Several disciplines within public health, such as behavioral sciences, health education and health communication, epidemiology and health services research, health policy, and health services administration and management, help to define the field of community psychiatry. Additionally, community psychiatrists have a significant focus on mental health promotion among individuals and communities, as well as the various aspects of prevention of mental illnesses, for which two classifications are described in this chapter. The public health perspective is an essential aspect of community psychiatry, and the field will be strengthened through opportunities for community psychiatrists to deepen their involvement in these activities.

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The Medical Model and the Public Health Model

The *medical model* is characterized by a primary focus on disease as a disruption of biological processes, and health care as a set of interventions and services meant to correct, and ideally cure, such biological disruptions. Engel's improvement upon the medical model, the *biopsychosocial model*, familiar to most psychiatrists, provides a "basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care," while taking into account "the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system" (Engel 2002, pp. 56–57). The ideology and intentions of community psychiatrists undoubtedly resonate with the biopsychosocial model, though given their reach beyond individual treatment to engagement with communities, the *public health model* is also pertinent to their work.

Public health can be considered to be "one of the efforts organized by society to protect, promote, and restore the people's health; it is the combination of sciences, skills, and beliefs that is directed to the maintenance and improvement of

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the health of all the people through collective or social actions; the programs, services, and institutions involved emphasize the prevention of disease and the health needs of the population as a whole" (Last 2001, p. 145). As such, the public health approach is focused much more at the level of the population than at the level of biological disruptions within individuals. Health, hygiene, and prevention are emphasized to a greater extent than treatment and curative efforts for individuals. When specific diseases are the focus of the public health approach, they are usually considered in terms of their occurrences and effects among communities or entire populations, rather than within a particular individual.

Key Domains of Public Health

Behavioral Sciences

Many schools of public health have entire departments focused on behavioral sciences, seeking to understand and enhance human behavior as it relates to health and disease. This discipline typically combines perspectives from health psychology, social science, anthropology, and sociology, aiming to develop and analyze models and theories that explain health-related behaviors and ways to modify such behaviors for the goal of health promotion and disease prevention. Such models include, but are not limited to, the Health Belief Model (Becker 1974; Harrison et al. 1992; Champion and Skinner 2008), the Theory of Planned Behavior (Ajzen 1991; Godin and Kok 1996; Armitage and Connor 2001), Diffusion of Innovations (Rogers 1995, 2002; Greenhalgh et al. 2005), as well as the Transtheoretical Model of Stages of Change (Prochaska and DiClemente 1984; Prochaska and Velicer 1997; DiClemente and Prochaska 1998), the latter having heavily influenced motivational interviewing approaches (DiClemente 1991; Swanson 1999; Rubak et al. 2005) in the clinical setting. The field of community psychiatry gains substantially from the behavioral sciences discipline of public health, given that psychiatrists' focus—both at the individual and the community level—commonly pertains to facilitating behavioral change (e.g., improved medication adherence, greater attention to healthy habits, better engagement in physical health screenings).

Health Education and Health Communication

Whereas the discipline of behavioral science largely focuses on developing and analyzing theory, health education and health communication tend to be a more applied field, seeking to increase health literacy (Nutbeam 2000), educate about health and disease, and communicate health messages to individuals and communities in the most effective ways. Relying heavily on cognitive and organizational psychology, communications, and marketing, key principles of health education and health communication come from Social Cognitive Theory (Bandura 1998, 2001; McAlister et al. 2008), Social Marketing (Lefebvre and Flora 1988; Hastings and Haywood 1991; Grier and Bryant 2005), and ecological models that focus attention on both individual and social environmental factors as targets for health promotion interventions (McLeroy et al. 1988; Stokols 1996; Sallis et al. 2008). Such theories aid in the development and dissemination of community-wide education programs that encourage people to make healthy choices. Again, this discipline is highly relevant to the work of community psychiatrists in light of its overarching goal to promote the mental and physical health of a community. Furthermore, psychoeducational approaches (developed to increase patients' knowledge of, and insight into, their illness and its treatment, Pekkala and Merinder 2002; Colom et al. 2003) have much to gain from recent advances in health education and health communication. Such advances include the use of low-text, visually engaging, interactive educational tools, as well as emerging eHealth (the use of electronic processes and communication to support healthcare services and practices) and mHealth (using mobile communication devices, such as smartphones, to promote health care and health communication) technologies.

Epidemiology, Biostatistics, and Health Services Research

The more numerical side of public health involves epidemiology, biostatistics, and health services research. Epidemiology, which arguably lies at the heart of the public health approach, includes the study of the distribution (e.g., incidence, prevalence, and course), determinants (e.g., biological, behavioral, and social factors that elevate risk), and outcomes (e.g., disability, morbidity, and mortality) of illness and injury within a population. Epidemiology as a field also develops and analyzes large datasets such as those derived from state and national surveys of health and disease (e.g., the National Health Interview Survey, the National Health and Nutrition Examination Survey, and the Behavioral Risk Factor Surveillance System). Along with epidemiology and biostatistics, health services research provides for empirical examinations of diverse problems relating to health, disease, and healthcare resources. Health services research is part of what defines community psychiatry, in effect being the "basic science" of the discipline. Community psychiatrists are ideally suited to this type of research given their interest in the provision of mental healthcare services—and improvements upon such services—for entire communities rather than just for individuals.

Health Policy and Health Services Administration and Management

Unlike traditional medical education and training, schools of public health commonly emphasize education and practical training experiences in health policy, as well as health services administration and management. Health promotion and disease prevention are commonly best effected through policy interventions, exemplified by taxation of tobacco products, seatbelt laws, improved safety engineering features of motor vehicles and other machinery, and rules requiring preschool immunizations. The field of health services administration entails policy and business administration skills required to manage the human and fiscal resources involved in delivering healthcare services. Again, because many community psychiatrists have an enduring interest in policy and leadership, they are particularly well aligned with this aspect of public health. Community psychiatrists may have well-defined administrative positions, such as being medical director of a program, service, agency, or organization. Although this is not as often the case today as it was in the past, when they do hold such positions, they are ideally situated to apply the prevention paradigms discussed below through these administrative roles (Compton 2007). Knowledge and application of public health and prevention principles may, in fact, play a part in helping to expand the roles of community psychiatrists to include more leadership activities.

Other Domains of Public Health

Other domains of public health may relate, though less obviously, to the work of community psychiatrists. In the public health arenas involving international and global health; environmental and occupational health; family, reproductive, maternal, and child health; exercise science; and nutrition, the focus once again pertains to communities and populations much more so than single individuals. Among psychiatrists, community psychiatrists are most likely to value and embrace these diverse domains included within the public health model, even though they may appear to lie outside the scope of the medical or biopsychosocial models to which most physicians ascribe.

Key Domains of Prevention

Several recent documents provide in-depth overviews of the field of mental health promotion and the prevention of mental illnesses. The extensive 2009 Institute of Medicine (IOM) report entitled *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities* (Institute of Medicine 2009) provides an update to the sentinel 1994 IOM report,

Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research (Institute of Medicine 1994). Worldwide approaches have been described in two key World Health Organization (WHO) publications, *Prevention of Mental Disorders: Effective Interventions and Policy Options* (World Health Organization 2008a) and *Promoting Mental Health: Concepts, Emerging Evidence, and Practice* (World Health Organization 2008b). These resources provide in-depth coverage of the various domains of prevention and mental health promotion that are briefly summarized below.

Primary, Secondary, and Tertiary Prevention

In the traditional public health classification of prevention, *primary prevention* refers to preventing a disease or adverse outcome from occurring, thereby reducing the incidence of a disorder. Primary prevention is exemplified by vaccinations to reduce the incidence of communicable diseases, fortification of food products to prevent nutritional deficiencies and related health consequences, and fluoridation and chlorination of public water supplies to reduce the incidence of dental carries and prevent enteric infectious diseases, respectively.

The field of mental health remains aspirational in terms of primary prevention, with few examples available to date. Nonetheless, preventive measures that reduce the onset of certain nutritional deficiencies (e.g., pellagra) and infectious processes (e.g., tertiary syphilis) associated with mental disorders undoubtedly have secondary effects in terms of minimizing associated psychiatric complications. Primary prevention in mental health may also occur via measures to reduce risk factors that are thought to be component causes of some psychiatric illnesses (i.e., neither necessary nor sufficient causes, but part of the constellation of risks associated with some cases of illness). For example, adverse childhood experiences are clearly risk factors for a number of psychiatric disorders (Chapman et al. 2007) and cannabis use in adolescence is thought to be a component cause of schizophrenia and related psychotic disorders (Ramsay and Compton 2011). Both of these risk factors can be prevented, and doing so could lead to a reduction in the incidence of mental illnesses (i.e., primary prevention).

Mental health promotion, which includes strategies and interventions that enable positive emotional adjustment and adaptive behavior, is intimately linked to primary prevention of mental disorders. It has been noted that the best opportunities for mental health promotion likely come through integration with broader wellness and health promotion efforts (Druss et al. 2010). Because mental health promotion goes beyond a focus on the individual (such that decisions made by businesses and government play a central role, Power 2010), like policymakers, community psychiatrists likely have the ability to influence mental health promotion within communities.

The goal of *secondary prevention*, which refers to early detection and screening, is ultimately to effect a reduction in the prevalence of a condition or disease. That is, if a disease is detected early, it can be treated promptly and ideally resolved; thus, early detection and intervention decreases the time the person has the disease, reducing the number of people having the disease at any given time (Compton et al. 2009). In general medicine, secondary prevention is exemplified by cancer screening measures (e.g., mammography, Papanicolaou (Pap) smears, and colonoscopy) and cardiovascular disease screening (e.g., assessment of body mass index, blood pressure, and lipid levels). Secondary prevention is an entirely feasible goal in psychiatry, as exemplified by screenings in the general public for symptoms of depression and screenings for suicidal ideation on college campuses.

Mental health professionals are not at all unfamiliar with *tertiary prevention*, which consists of rehabilitative treatments that reduce disability. Tertiary prevention is exemplified in general medicine by rehabilitation after a cerebrovascular accident to minimize functional impairment. In psychiatry, tertiary prevention involves preventing relapse, reducing the likelihood of developing comorbidities, and providing treatments to

enhance psychosocial functioning (Compton et al. 2009), such as assertive community treatment, family psychoeducation, integrated substance abuse treatment, social skills training, supported employment, and supportive housing.

Indicated, Selective, and Universal Preventive Interventions

The 1994 and 2009 IOM reports mentioned above further classified primary prevention by emphasizing the target population addressed by the intervention. In this newer classification, primary prevention is subdivided into universal, selective, and indicated preventive interventions. Most broadly, *universal preventive interventions* target the entire population without regard to each individual's level of risk, as exemplified by fluoridation and chlorination of drinking water, fortification of food products, and legislation prohibiting the use of handheld electronic mobile devices while driving. In the mental health field, such interventions may include public service announcements or media campaigns designed to reduce the initiation of substance abuse.

Individuals within a subgroup of the population whose risk of developing a specific disorder is substantially higher than average would benefit from *selective preventive interventions*, such as lifestyle and pharmacologic management of hyperlipidemia to prevent cardiovascular disease among those at elevated risk by virtue of their Framingham score. In mental health, an example of a selective intervention is one designed specifically for children at high risk for depression due to having a parent with an affective disorder (Beardslee et al. 1997).

Finally, *indicated preventive interventions* target particularly high-risk individuals who do not yet meet diagnostic criteria for the illness but can be identified as having a biological or psychological marker indicating a definite predisposition to the disorder. One example within psychiatry is the identification and treatment of individuals at "ultra-high risk" for schizophrenia (i.e., those with symptoms consistent with the prodrome), though they do not yet meet criteria for a psychotic disorder diagnosis (McGorry et al. 2009).

Benefits of Incorporating the Public Health Approach

In 1964, Caplan stated that "the public health approach of organized community planning for comprehensive programs to include prevention, treatment, and rehabilitation of mental disorders and to be coordinated with other community programs in the health and welfare fields has found a ready ear among many psychiatrists" (Caplan 1964, p. 10). While the previous sections have suggested that contemporary community psychiatrists already resonate with many aspects of the public health model, a more intensive embrace of the public health approach would benefit the field of not only community psychiatry but also public health. The work of community psychiatrists is enhanced through close ties with diverse disciplines within public health. For example, the development of psychosocial interventions for patients with serious mental illnesses is assisted by the application of behavioral science models and theory; modern psychoeducational programs benefit from collaboration with professionals involved in health education and health communication; and the evaluation of community mental health services is advanced through partnerships with health services researchers housed in schools of public health.

Practicing the Principles of Prevention

The field of community psychiatry has an enduring interest in prevention. The Kennedy-era community mental health movement incorporated proposals of prevention, though they may have been overly optimistic at the time (Bachrach and Clark 1996), and sustained funding for preventive efforts was not available in the ensuing years. At present, it would appear that cautious optimism remains warranted with regard to primary prevention (Paykel 1994), though secondary and

tertiary prevention are more advanced and more extensively implemented. Thus, while additional research on the primary prevention of mental illnesses accumulates, all other aspects of prevention are ready for further development and implementation, and community psychiatrists are ideally suited to lead these efforts.

A previously outlined list of eight principles that mental health professionals should consider in their effort to become prevention-minded mental health professionals seems particularly relevant to the work of community psychiatrists (Compton et al. 2009):

1. Knowledge of epidemiology is the basis for the application of preventive efforts in mental health.
2. Practicing prevention in the field of mental health requires an understanding of risk factors and protective factors.
3. Evidence-based preventive interventions can be applied in the clinical setting.
4. Important goals for patients with established psychiatric illnesses include the prevention of relapse, substance abuse, suicide, and unhealthy behaviors that lead to physical illnesses.
5. Clinic-based preventive efforts should include family members of individuals with psychiatric illnesses in addition to the individual themselves.
6. Primary and secondary prevention efforts can take place in schools, the workplace, and community settings.
7. Mental health professionals should have a role in broad prevention activities (beyond the prevention of mental illnesses), such as the prevention of delinquency, bullying, physical health problems, teenage pregnancy and/or unwanted pregnancy, and the prevention of intentional and unintentional injuries.
8. Mental health professionals should play a role in mental health promotion, overall health, and wellness.

Community psychiatrists take part in diverse activities in which these principles are applied, such as conducting health services research to inform the epidemiology and treatment service needs around mental illnesses; having a commitment to engaging families in the care they provide to individual patients; serving on and lending expertise to boards of local agencies and organizations; and attending to the whole health of their patients, including various psychosocial issues.

Toward Further Integration of Public Health, Prevention, and Community Psychiatry

As described in other chapters throughout this book, much of the work of community psychiatrists pertains to providing services to individual patients and their families. In doing so, community psychiatrists aim to enhance outcomes and quality of life, promote recovery and resilience, and partner with patients as they work toward developing a meaningful life despite the presence of a mental illness. Yet, community psychiatry also has broader goals pertaining to the community at large. The embrace of the public health model and the principles of prevention effectively advance these goals. In recent years, some community psychiatry fellowship training programs have explicitly set out to combine the medical model and the public health approach, and have provided fellows with graduate training in the public health disciplines (Kotwicki and Compton 2010). These and other formal associations between community psychiatry and public health and prevention enrich the work of community psychiatrists, advance programs intended to enhance the recovery of their patients, and benefit society at large through the collective actions of this strengthening subspecialty within psychiatry.

While the field of community psychiatry is intimately tied to the public health and prevention perspective, this perspective is not incorporated into common practices as much as it could be. This is driven to a large extent by the ways that systems of care are organized, which is in turn determined largely by healthcare financing. Many public health departments are quite separate from, and often have minimal communication with, public mental health departments. Financing of preventive services is complex and controversial. The cost of providing preventive

services is substantial without clear evidence, in many cases, for the economic advantage of providing them. While the humanitarian argument may be more convincing (Rose 2008), not everyone values this ideology. Despite this, with its strong commitment to social justice, community psychiatry is uniquely positioned within the field of mental health to have a significant impact on the implementation of the principles and practices of public health and prevention. Indeed, the tenets of public health and prevention are essential aspects of community psychiatric practice, despite some significant obstacles to realizing their full potential. Ways of transcending obstacles related to separation of mental health from other public health services—and financial constraints—rest largely upon changing mindsets and changing policy, which are active goals of the community psychiatry discipline.

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Financing of Community Behavioral Health Services

5

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Introduction

It is essential for community psychiatrists and other professionals and stakeholders in our community behavioral health system to understand the fundamentals of financing of Community Behavioral Health Organizations (CBHO). Healthcare financing in the United States is complex and operates at many levels: from the capture of a simple single fee for service (FFS) to much more complex payment structures and cost management mechanisms that apply to payer system interactions. Government sources play a much more prominent role in the financing of behavioral health services than for general healthcare (National Healthcare Expenditures 2003). Medicare, local government grants, and Medicaid are the predominant payers of behavioral health services delivered in the United States. In order to develop a framework from which to understand financing of community mental health care, this chapter begins with describing a rationale for understanding financing, then discusses the essential structural components of CBHO financing, and proceeds to examining the historical development of public funding mechanisms, particularly considering the developmental roles of local, state, and federal governments. From this examination and detailed description of the current state of CBHO funding, speculation is provided into possible future developments, particularly with regards to health policy in the first several decades of the twenty-first century.

Why Understand Behavioral Health Financing?

Understanding the components of system financing is a first step in developing the capacity to influence services development at local, state, and national level. Financing is often not included as a component of professional, and particularly psychiatric, training and when it is, often it is included as a secondary "necessary evil" rather than a core element. Only recently have elements of understanding systems of healthcare been included among the core competencies of postgraduate medical education (ACGME 2000–2011). These core competencies have been developed to assure that all physicians are appropriately equipped to function effectively in

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clinical and administrative leadership roles in the complex US healthcare system.

Community psychiatrists may have a designated leadership role as medical directors or chiefs of service or they may be in direct care provision in staff psychiatrist roles. Often in CBHO staffing patterns, a psychiatrist interacts daily with multiple clinical staff on a variety of levels. Primarily because of the relative expense of psychiatric time, there is often pressure to limit professional and psychiatric services to the provision of direct care. Psychiatrists who are able to effectively engage with executive leadership often find their jobs to be stimulating (Ranz et al. 2001) and this leads to limiting the professional burnout that can be quite frequent in CBHOs for psychiatrists and all professional staff. Moreover, this engagement can create a healthy synergy between individual psychiatrists and CBHO management.

Understanding the evolution of the societal role and financial context of community behavioral health services development provides a necessary foundation to effective leadership within a CBHO. Additionally, participation as an effective advocate for positive changes in the CBHO services system requires a good working knowledge of the context and financing of services. The advantage in having state government so integrally involved in Medicaid mental health benefit design, for example, is that state government officials are generally accessible and are formally accountable to citizens who are their constituents. This provides an important opportunity to understand that advocacy is possible in service development.

In considering the development of mental health services, we have seen movement from a community service system marked by basic humanitarian and public safety elements to one requiring complex financing and sophisticated business management just to hire staff and provide services. Moreover, the cost of care has risen alarmingly in the past few decades, causing increasing emphasis on how to control it (Marks 2003). At the same time, attention to the quality of services has grown and service providers have greater accountability. The challenge for the service system is how to create a balance among these forces, using financing creatively to achieve good outcomes at a reasonable cost. The challenge becomes greater as resources dwindle. Whatever other controls are put in place, who gets paid, how they get paid, and who holds financial risk, largely determine the type and quality of services provided (The American College of Mental Health Administration 2003). The financing mechanisms we invent create incentives supporting certain behaviors and if we do not recognize those incentives, we will often be left with unintended consequences. Understanding incentives will enable service design to achieve desired results. The trend to consciously consider and promote incentives in services system design is relatively new. Earlier mental health system designs were more simply related to public service and public safety. Incentivization is associated with a move into the modern fiscal and business world.

How Are CBHO's Funded?

CBHOs are typically funded through multiple sources, predominantly governmental. Only a small portion of funds are from private insurance, self-pay, or philanthropy. In general, local, state and federal governments are involved in funding CBHO services in different ways and a useful way to categorize government funding is to consider these three. Local government includes county and city government. An example of county funding might be a grant that would support school-based mental health services in a school system. State funding for CBHO services is predominantly through Medicaid; however, states may also fund CBHO services through general funds under the direction of state mental health authorities. The kinds of programs that Medicaid funds are broad and they are defined by a state Medicaid plan. Examples of CBHO services that are commonly funded by Medicaid include supported employment, targeted case management and therapy. Federal funds that come to CBHOs are predominantly through the federal portion of Medicaid and Medicare and

some funding may be available to CBHOs through the Federal Mental Health Block Grant (MHBG) or other demonstration project grants. This chapter centers on funding related to professional services provided within CBHOs, though many consumers of CBHO services are also involved with other government programs such as social security, prescription medication coverage, social services, housing programs, and/or food stamps (Frank and Glied 2006).

Rules and Regulations Govern Access to Funding

The types of rules or regulations that CBHOs are subject to as a prerequisite for funding range from local government laws such as building and fire codes, to state mental health agency licensing regulations, to state human rights laws. It is common for CBHOs to be licensed by state governments and the requirements for such licensure varies by state. Requirements range from the very rudimentary to extremely complex clinical, human rights, and operational standards. Licensure is typically defined in a state legal code and may be required for the State's Medicaid plan in order to qualify for federal approval of Medicaid reimbursed services.

CBHOs often are accredited by The Joint Commission or an organization called CARF (Commission on Accreditation of Rehabilitation Facilities). Joint Commission or CARF accreditation may be a requirement of state licensure and may be a requirement to participate in Medicaid funding. Another set of standards that may be required by payers are the professional credentials of staff. CBHOs are typically staffed with a wide range of professional and paraprofessional staff. It is not uncommon for payers to require a certain level or type of staffing. An example of this might be an assertive community treatment team that must have a registered nurse and psychiatrist accessible 24 h a day. Some behavioral health billing codes can only be billed by professionals with specific credentials or teams with a specific minimal combination of professional and paraprofessional staff. Historically, many CBHOs were allowed special status to bill for professional services provided by staff who were not fully licensed as independent mental health professionals. This special circumstance allowed CBHOs to hire new graduates who had finished coursework but not all of the necessary clinical supervision to sit for a licensing examination, or had taken and not yet passed a licensing examination or were grandfathered in as professionals due to tenure at an agency or degree of supervision in lieu of completion of a professional graduate degree and a licensing examination. Increasingly consumer participation is encouraged or required as a component of the CBHO workforce. Consumers often serve as members of a governing board which is often required by state licensure and they may also work as direct care providers as peer support specialists.

The following section presents the development of the public mental health system in terms of financial resources. While chronological, it is not intended to be a history lesson as much as a description of the relative roles of various funding sources and of stakeholders so that trends in financing and their impact are clear. Understanding the development of mental health services in terms of what citizens, through their government, are interested and willing to finance is essential in understanding the current financing trends.

Community Mental Health Financing Through Time

Communities have long had a role in addressing the mental health of the people who live within them. Communities with high social capital and high engagement of members thrive and produce more successful individuals than do communities with low engagement (Putnam 2000). By its basic nature, a community supports the common good and well-being of its members. In broad terms, this serves as a kind of prevention activity.

In thinking about how communities address mental illness, a concept of "loud" and "quiet" mental illnesses is useful. Quiet mental illnesses are those associated with internalizing illnesses, such as depression and anxiety. Quiet and

internalizing mental illnesses generally do not represent a public safety risk and affect a community through loss of social roles. For example, a father with depression might not be able to maintain the family farm, attend work regularly, or advance to community leadership roles. Loud or externalizing illnesses are characterized by obvious, disinhibited, or positive symptoms that might pose a threat to the person or material objects of others. As such, a young woman who has a paranoid delusion that electrical substations are sending electricity to children's brains to brainwash them and then destroys the substation with an axe so that electricity is shut down to an entire community would be a challenge for communities to tolerate. Communities have primary interest in containment of those with loud conditions that pose a literal threat to the safety of its members. The spectrum of mental health services over time has moved from basic containment of externalizing, loud conditions to a more comprehensive capacity to, and interest in, also addressing quiet internalizing illnesses that are likely to adversely impact productivity and well-being. Public debate continues regarding the degree to which public funds should be limited to the containment of individuals with externalizing threatening illnesses vs. support for a wider array of services to individual with quiet internalizing illnesses through the provision of prevention, early intervention, and treatment.

In American society, communities have financed structures since early colonial times. The aims and relative roles of various funding sources have changed over time. For the purposes of organization, this chapter is divided into four eras: a Dark Ages Era, the Institutional Era, the Community Tools Development Era, and the Recovery Era.

Dark Ages Era (Before 1800)

The term *Dark Ages* connotes a period in post-Roman Europe when civilization was inconsistently organized and did not operate from a predictably fair framework. Just as the Dark Ages in European history describes a period of inconsistent ideology and uneven justice, so too does the term "dark ages" describe the situation of the approach in the United States to persons with mental illnesses before about 1800. As the ideology of humanism among thought leaders of the Renaissance brought an end to the Dark Ages, so too does the ideology of moral treatment and humanism bring the end of a "Dark Ages Era" of mental health services in US history.

The colonial approach to managing mental conditions often centered on providing protection through containment of individuals with loud, externalizing mental illness who represented a threat to others and the community. Containment occurred in jails and sometimes with shackles or cages and these places of confinement were supported by local community funds that were generated through taxation. In the Dark Ages Era of mental health services in the United States, individuals with internalizing conditions, and their families, had no common community resources available. Social services needs were typically provided informally by extended family, neighbors, or faith-based groups. Later, many communities developed the fiscal capacity to provide alternatives to incarceration for some through the development of alms houses which were designated for "social dependents" or persons who were unable to work to provide for themselves. Almshouses and similar institutions were most often funded by city or county local government sources.

The dark ages era was gradually replaced by moral treatment ideology which has roots in the humanism of the european renaissance. Dorothea Dix is widely credited with being a major force in catalyzing the development of the state mental hospital system which promoted the humane treatment of mentally ill individuals. Dix, the daughter of a colonial minister, centered her advocacy on the provision of more humane treatment of individuals with mental illnesses. Humanism is the foundation for universal human rights, and at its very core, human rights asserts a right for every human to pursue an autonomous function that is not unfairly impeded by others. Dix conducted tours and inspections of prisons

and almshouses where individuals with mental illnesses were contained and recorded her observations in a series of reports called memorials. These memorials exposed the inhumane and deplorable conditions within these places. Limited and inconsistent funding primarily from local government sources was often cited as a reason for these wretched conditions. She aggressively promoted the idea that state governments were much more likely to have the larger and more stable financial resources necessary to consistently support proper treatment institutions.

Through her repeated, passionate, and consistent advocacy, she and others promoted a more humanistic, fair, and just approach to individuals with mental illnesses. Advocates of this era were very clear that moral, humane treatment was a financial and social responsibility of a civilized government. The construction of regional- and state-funded asylums was the way to bring the inconsistency and often inhumane conditions of the Dark Ages Era to an end. This was at a time in American history wherein the federal government was very young, having just recovered from financing the War of 1812 and still working out issues related to the role of the federal government in levying taxes. A significant political event of this era articulating the federal government's decision to opt out of mental health (and social welfare) financing was Franklin Pierce's 1854 presidential veto of Congressional legislation championed by Dix that would have set aside revenue from the sale of several million acres of federal land for the indigent insane. Pierce reasoned that it was not the role of the federal government to provide for the social welfare of citizens.

The role of state vs. federal governments was actively debated and it was widely accepted that social concerns would be the primary financial responsibility of state governments. The federal government, in comparison, would be responsible primarily for a common defense, international diplomacy, and the establishment of a common justice framework or judicial system. The debate regarding the appropriate relative roles of federal, state, and local governments in the provision of social and healthcare services is ongoing today.

The Institutional Era (1800–1950)

In the early 1800s, asylums first began to be built in the United States and, as noted, these were mostly financed with state capital funds. The asylum buildings were often designed by leading architects and held as a symbol of a state government's civility and humanitarianism. Whereas earlier alms houses and poor farms were built for social dependents by local governments, asylums were built more specifically for the indigent insane and were predominantly funded by state governments. Some private and faith-based institutions did exist, but the predominant model was state-funded institutions. Patients with families of means were expected to provide financial support for their institutionalized family members in varying degrees including inheritance and trust funds. In general, state asylums were expected to be as self-sustaining as possible and only what could not be produced or grown within a facility was obtained through direct state fund allocation. Many of the routine needs of these growing asylum communities were met with uncompensated patient labor which was also considered to be part of the treatment. Patients were involved in maintaining asylum farms for produce and livestock that would be used to feed patients and staff. Other facility jobs that helped to sustain the operation of facilities included clothes making, food preparation, and building and grounds maintenance. Some facilities had surplus crops that were sold for profits that were used to support the institution. Hospital budgets were commonly a part of the state general budget. As the proportion of state funds necessary to operate these institutions grew, states began to form state departments of mental health. As the number of asylums grew within a state, a state typically would create geographic catchment areas such that asylums were responsible for the needs of the subpopulation of people with mental illnesses within that area. Though not in its contemporary sense, one might

use "capitation" for this arrangement of the asylum being allocated a fixed sum of money to provide treatment to a given population. From the perspective of the consumer, this system resulted in a kind of soft "entitlement" in that individuals with mental illness within an area had an asylum that served that area. Many asylums had very limited ability to restrict admissions, particularly of individuals legally committed to their facility for treatment. This typically resulted in admissions occurring at a higher rate than discharges. Throughout much of this era, there were virtually no community providers to refer individuals to. The role of the state mental health department was to advocate and broker the needs of the asylums with a governor and/or elected state government officials. New buildings and institutional growth was supported through increased allocation in state government budgets. Within a state asylum, progressively called state hospitals, the superintendent generally had a great degree of autonomy regarding level of staffing, quality of treatment, and program development.

It has become common to think about incentives in contemporary healthcare financing. In the Dark Ages Era of mental health services, the development of fledgling mental health containment services was associated with protection of the public and of individuals. Elected officials were accountable (incentivized) to their community to protect society by the removal or isolation of individuals who were perceived to be dangerous. Similarly, the concept of incentive in the Institutional Era is tied to the social mission of public safety as well as the fulfillment of the humanitarian ideal to provide asylum and potential cure for disturbed individuals. Facilities were incentivized to advocate for and obtain increasing funding levels from the state to resource an asylum.

By 1940, the census of US facilities had reached 450,000 (Grob 1983). These state institutions had become large, expensive, crowded, and challenging to manage. Very little in the way of outpatient and community-based treatment existed. As the Institutional Era drew to a close, the majority of mental health services were provided through large facilities that were primarily state financed, albeit with several private asylums and hospitals funded through private contributions and fees.

The Community Services Development Era (1950–2000)

At the outset of the Community Services Development Era, attention and emphasis shifted from state government-funded long-term institutional care to the development of community supports. Conceptually, community services would be able to provide continuity and treatment services to individuals that could be discharged from institutions. As a part of the New Frontier policy initiative of the Kennedy administration, the Mental Retardation Facilities and Community Mental Health Centers Construction Act was enacted in 1963 (Cutler et al. 1992). This Act is significant as it represented the first significant foray into funding of community mental health by the federal government. Aligned with the concept "New Frontiers" was the idea that individuals within institutions could experience new opportunities and new frontiers in community settings. In contemporary parlance, we might use the term "federal stimulus" in that the funding for mental health was not to be used to support operations or services so much as the necessary infrastructure development to develop and build mental health services in a community. Under these grants, federal funds diminished to zero over a 5–8-year period, after which other sustainable funds for ongoing services were to be established by the community and from local county/city government or the state's department of mental health funding. Federal grants developed under this law were made available to communities and included the designation of 3,000 catchment areas, each containing between 75,000 and 200,000 persons wherein five essential services would be provided. These services included: inpatient, outpatient, day treatment, emergency services, and consultation and education services.

Medicare and Medicaid were both enacted in 1965 during the Johnson Administration.

These two programs were complimentary in providing a national framework for a humane healthcare safety net for the nation's most at-risk individuals, the aging and the extremely poor. In 1964, State of the Union Address President Johnson announced his declaration of the War on Poverty as a major initiative of his challenge for America to become a truly Great Society. Medicare and Medicaid were important components of this ideology.

As services evolved, matured and diversified within the Community Services Development era, so did the funding that enables services to be provided. At the outset of the Community Services Era, the costs for any of the rare community services that did exist were generally paid from state general funds that may or may not have been carved out from state hospital budgets. Local county and/or city governments often supplemented state funding for the special needs of their community. By the end of the community Services Development Era, funding for community-based services has evolved into a very diverse and complex amalgam of resources. In order to understand the context and perspective of current funding streams, it is necessary to examine the component revenue elements. An understanding of the origin and role of the CBHO revenue elements will help with an overall understanding as to how they fit together to create the patched, braided, or mishmash of revenue sources that support contemporary CBHOs.

As Medicaid developed, states began to transition from grant or program funding supported by state or county funds to current FFS financing. FFS denotes reimbursement for discrete episodes of services. For example, to provide an after school adolescent program for adolescents with serious emotional disturbance, fees to the program are not paid until the patient receives the service and the fees are only paid for days the person actually attends. This FFS transition or "Medicaidization" of community services resulted in some dramatic shifts in incentives. With grant funding, governmental entities would contract with providers to offer services to a defined population, or to catchment areas (Buck 2003). This approach has certain advantages that include few restrictions on the types of services provided, and providers can be flexible and creative in designing service plans. Since the served population was fixed, providers could potentially focus on long-term outcomes and prevention. At the same time, this arrangement created some problems that eventually led to its demise. Providers held no financial risk, and often, overspending was rewarded with supplemental allocations at taxpayer expense. Outcomes were not uniformly defined, and providers had little accountability for results or serving all persons within their catchment, including those with the most severe mental illnesses. Catchment area organization did not give consumers a choice of their provider, so there was no competition between providers to attract "customers" by providing a better product. In the end, neither quality nor economy was served well.

FFS creates very different incentives. Without catchment areas, providers compete for customers and presumably attempt to provide a superior product. They must be efficient in the way they use their resources in order to cover expenses or they will incur uncompensated losses. While this arrangement does allow a greater degree of uniformity and accountability, with a defined set of established "billable" services, it limits creativity and nonbillable activities such as consultation, integration, prevention, and team interaction. It rewards entities that produce more billable hours or procedures. There is disincentive to provide services to persons requiring intensive support beyond a billable service, and the process of billing itself creates administrative costs. Competition can provide an incentive to improve quality, but only when the supply of services is greater than demand for them, which is seldom the case in the public sector.

Medicare

Medicare provides a foundation to understand government health financing mechanisms and it is presented here first because it is more straightforward in design and administration. Medicare was developed from federal programs that provided medical care for the aging widows of United States veterans who would otherwise not

have access to health insurance through veterans benefits or employee-based insurance (because husbands were deceased and therefore not employed). Currently, about 84% of Medicare beneficiaries are persons over the age of 64 and, about 16% of all Medicare beneficiaries are Medicare recipients because they are disabled (Kaiser Family Foundation 2009 data). There is not an income test for Medicare eligibility. Since 1973, individuals who have been determined to be disabled by the Social Security Administration are eligible for Medicare.

The federal government funds 100% of every Medicare dollar and the program is managed by regional carriers that, in turn, define specific regional policies. As of 2001, Medicare provided about 15% of the total funding for inpatient, outpatient, and pharmaceutical mental health services spent in the United States and at that time there were just fewer than 40 million Medicare beneficiaries (National Healthcare Expenditures Report 2003). Most Medicare mental health payment is for inpatient treatment, and in 2001, mental health expenses comprised only 2.4% of the total Medicare health expenditures (National Healthcare Expenditures Report 2003). Medicare may pay for partial psychiatric hospitalization and home health and general outpatient psychiatric treatment, but the program does not pay for many of the rehabilitative services that CBHOs often provide, such as case management, rehabilitation programs, or assertive community treatment. When persons have Medicare and Medicaid (also known as being a "dual eligible"), Medicaid is the payer of last resort and is used only if Medicare or any other benefit a person might have does not pay for a service.

Medicaid

From its inception in 1965, the impact of Medicaid on mental health services has evolved tremendously. Originally, Medicaid was developed to replace a combination of federal grants and payments to physicians and hospitals for the treatment of needy individuals. In 1965, Medicaid was created by federal legislation as a state-operated and dually financed (state and federal government) healthcare insurance program for the poor. State governments finance 50% or less of the total payment for healthcare services, with the federal government paying the remaining portion. The part that the federal government pays is also referred to as the Federal Medical Assistance Percentage or FMAP. About one quarter of states, those with highest income per capita, have a 50/50 FMAP. The FMAP for the remaining states is generally between 51 and 75% and states with the lowest per capita income have the highest FMAP.

Eligibility for Medicaid is based on means. This includes annual income to a household as well as consideration of the assets an individual possesses such as bank accounts and real estate. The income eligibility requirement for Medicaid is determined by each state and is codified in each state's Medicaid plan. Eligibility was originally associated with receipt of other federal welfare programs such as Aid to Families with Dependent Children (AFDC or ADC) and most recently has been shifted to an annual household income test that is keyed to federal poverty guidelines. Federal poverty guidelines are established by the Department of Health and Human Services (HHS) as an eligibility criteria reference for several federal programs including Medicaid. For example, if a state determines that the Medicaid eligibility level is 200% of HHS federal poverty guidelines, individuals or families earning up to 200% of this figure are eligible for that state's Medicaid program. Likewise, a state Medicaid plan that has 90% federal poverty guideline eligibility means that only individuals or families who earn less than 90% of the poverty guideline are eligible. This provides a mechanism through which regional cost of living, state taxation rates and revenues, and other factors can be taken into consideration. Eligibility can also be determined by special population needs. Some states limit Medicaid eligibility to poor children and women of child-bearing age, whereas others include persons who are poor and disabled, blind, and/or aged. Traditionally, and in keeping with general American social policy ideology that able bodied men should not be encouraged to become dependent on government programs, men are traditionally the least likely to be eligible for Medicaid.

In order to participate in the Medicaid program, a state must create and propose a state plan to the federal Center for Medicare and Medicaid Services (CMS). Once approved, the plan serves as a kind of contract between the state and federal governments. Any state-initiated amendments, waivers, or other changes to the state plan must be reviewed against federal regulations and laws and approved by CMS. Initially, the services that CMS allowed Medicaid to pay for were traditional healthcare services such as hospitalization, outpatient physician visits, and nursing homes. In general, *amendments* are used to make proposed changes to the existing approved state plan and *waivers* have been used to propose specific alternatives to expensive long-term care or institutional costs for a particular population. Waiver applications from a state Medicaid office typically must demonstrate that they are no more expensive to operate than long-term institutional care. Waivers in many states are well developed for individuals with intellectual or developmental disabilities who otherwise would be housed in facilities such as a specialized state-operated care facilities called intermediate care facilities, or ICFs. Medicaid waivers are also used to fund alternative services to nursing home care. The ideology of using waivers as mechanisms that enable the redirection of funding from long-term institutional care to community-based treatment has been important in the financing of certain services in the CBHO.

Community Services Development Era

Medicaid funding of community mental health services has increased dramatically over the last several decades such that Medicaid is now the largest payer for community mental health services in the United States (Buck 2003). The increased ability of states to access matching federal dollars greatly facilitated service development in this era. There was great appeal for every million dollars a state spent to provide outpatient services to have federal matching funds, creating two million dollars in services. Medicaid pays for inpatient psychiatric treatment in non-IMD facilities such as psychiatric units in general hospitals. However, because of a special condition in the original federal Medicaid legislation, Medicaid cannot be used to fund any services within a freestanding institution of mental diseases, or "IMD." By definition, an IMD is a freestanding psychiatric hospital with more than 16 beds. This provision, the IMD exclusion, was created so that states would not be able to shift the responsibility state government has long held for provision of long-term care and treatment of indigent individuals with mental illnesses to the federal government. This policy has had the longer term effect of enabling the development of community services and the closure of many expensive state psychiatric hospitals.

A crucial element in considering Medicaid and its role in services development is recognition that Medicaid's FFS structure. FFS does not permit a community agency to receive a bundle of funds to operate a set of services for a population. In contrast, grant or *capitation* of funding sources might finance a certain dollar amount to provide a certain intensity in all aspects of programming for a specific target number of service recipients (or single individual in the case of capitation). Therefore, under traditional "unbundled" Medicaid FFS funding, there is limited capacity to support planning, start up, and general services administration costs.

Another important concept to understand in the financing of CBHO services is that Medicaid services are an entitlement. While states have a great degree of latitude regarding establishing the rules for eligibility levels and the range of services that are offered, once a person is determined to be eligible for Medicaid, he or she is entitled to all the services that are available and medically necessary for a given condition.

In consideration of incentives under a simple FFS structure, health organizations that provide more services to more individuals receive greater revenue. Understanding the possibility of financial incentives that might impact CBHOs and delivery of Medicaid behavioral health services is more complex than a simple FFS arrangement. Medicaid typically has low reimbursement rates particularly for physicians and professionals

compared to Medicare and other health insurance plans (Zuckerman et al. 2009). CBHOs typically address this financial gap through close management of physician and expensive professional staff productivity and through cost sharing from the direct care and administrative revenue of other incorporated programs that have a greater difference or margin between expenditures and revenue collection. In general, the larger an organization is, the larger the wiggle room or margin there is to pay for a range of professional and paraprofessional staff. Some CBHOs have grown specifically in order to have a larger or more stable source of revenue from a diversity of programs; others have not been able to maintain sufficient revenue to provide services or continuously operate at the margin.

Federal Mental Health Block Grants

This source of federal funding for mental health services and administration began in 1981 under the Reagan administration. The establishment of the Mental Health block grant (MHBG) was a compromise that followed the repeal of several significant mental health provisions that had been passed in 1979 during the Carter Administration in response to the report of a presidential Mental Health Commission (Sharfstein 1982). These funds are issued to state mental health authorities and require that states create a comprehensive state mental health plan that must be developed by a statewide planning council. For many state mental health budgets, the MHBG funding is a very small proportion of the whole mental health budget. However, this funding is not tied to individual patients and can be used much more flexibly in that it resides outside federal Medicaid regulatory purview and can provide for planning and program administration in ways that FFS designs, like Medicaid, cannot provide. For many states, the MHBG is 1% or less of the total expenditures on mental health services.

Local Government Grants

Grants provided to entities for particular services are an important component of overall funding for community mental health services. These funding mechanisms take several different forms. They can range from support for broad administrative services as a recurring expense in a county or city government budget to very specific specialized programs funded through time-limited grant instruments. Examples of these types of grants include: in-school or after-school professional services, summer camps for kids with serious emotional disturbances, employment programs, mental health services in shelters, and community-wide mental health first aid programs. In 2003, the federal Substance Abuse Mental Health Services Administration (SAMHSA) determined that local government entities contributed 24% of all the expenditures for mental health services to Americans (Mark et al. 2007).

Managed Behavioral Healthcare

Managed care emerged in the early 1980s as a mechanism to reduce costs, particularly the costs of psychiatric inpatient admissions that were paid for by private insurance. As state governments reduced the numbers of long-term state psychiatric hospital beds, community inpatient units, private freestanding psychiatric hospitals, and outpatient resources grew. The IMD exclusion provision in Medicaid law provided a strong incentive for state governments to move individuals in state hospitals (which are IMDs) into treatment in acute units in general hospitals. Individuals in need of psychiatric services and with some form of insurance were usually admitted to freestanding private psychiatric facilities or general hospital psychiatric units. Because of rising costs and high variability in utilization elements, particularly length of stay, managed behavioral healthcare was developed and supported by the insurance industry as a way to address costs and adopt more standardized clinical practice. Several new cost containment techniques were developed by the managed behavioral healthcare industry. These techniques include attention to standardizing admission criteria, length of stay, and price of the service. Admission criteria became more standardized through the development of the concept of *medical necessity*. A medical necessity criterion is a standard and written set of conditions that must be met in order

to access a service. Examples of the types of medical necessity utilized by managed behavioral health companies include: the presence of certain diagnoses, level of acuity of the condition, presence of particular symptoms, failure of prior lower levels of treatment to stabilize a condition, and level of impairment or dysfunction. Length of stay in inpatient settings has been intensely managed such that a length of stay may be 5 days or less, whereas in the premanaged care era a length of stay may have been as long as 30–45 days on an acute psychiatric unit and as long as years in a state institution. In general, prior to managed behavioral care, there was greater ability for physicians, professionals, and patients to direct the care they believed was best for a given clinical situation. With managed care, a much sharper focus was placed on costs and standardized treatments; patients and physicians were put in the position of having to *prove* the need for a particular level of service to justify the insurance claim for payment.

In the mid-1990s, Massachusetts was the first state to contract with a behavioral health-managed care company to manage the costs of public funded mental health benefits for Medicaid recipients. Within a decade, over 45 state Medicaid programs contracted with behavioral healthcare entities to manage the costs of state Medicaid expenditures (Sturm 1999). Managed behavioral healthcare techniques generally have been successful in standardizing services and in reducing cost increases. State Medicaid programs that contract with behavioral health-managed care entities may have one of several different types of arrangements. Behavioral health benefits may be managed in the same way that general health is managed or behavioral health may be carved out to a specialized behavioral health management company. Within the behavioral health set of benefits, services can be managed in one of three broad types of arrangements. The first of these is a full-risk arrangement such that the managed care entity assumes the entire management of and financial risk for mental health services to a population. In this arrangement, the managed care company has potential gain or loss depending on the number and cost of services delivered. Inherent in this arrangement is a financial incentive for the managed care entity to limit the number and intensity of services provided. A part of the public concern about the managed care model being so integrally involved in the management and allocation of public funds for services is that the presence of a managed care entity creates a layer in the relationship between government and the citizens—constituents to which government officials are accountable.

A second arrangement structure that a state might employ to manage Medicaid mental health benefits is a partial risk structure wherein the behavioral health-managed care company has a range of potential risks and losses with the state bearing the full potential risk or gain in the management of services. This type of arrangement puts caps on the potential profit or loss that private managed care companies can earn when administering or managing the public Medicaid dollars. A third style of arrangement is a no-risk arrangement wherein the state Medicaid program contracts with a managed care company for a set fee to support the utilization management of services. In this third type of arrangement, also referred to as an administrative services only, or ASO, arrangement, the managed care company does not have financial risk for profit or loss, rather it is hired and paid to perform a specified set of management services.

Overall, the rules and rates created by the managed behavioral healthcare industry have been strongly shaped by the technology of powerful data systems that provide accurate and timely information on claims. Many state government information technology bureaucracies, particularly state offices of mental health that are not directly linked to state Medicaid claims information, do not have the capacity to effectively manage large population utilization data without outsourcing to managed behavioral health entities. The modern information technology capacity of managed care companies has increasingly become more sophisticated over the last several decades and has resulted in managed care entities influencing policy development from the perspective of trends in cost and claims-based data as opposed to a more traditional public health

model of assessment of population health needs and the development and funding of treatments that meet those needs. A central policy question is: has the insertion of the business of managed care resulted in a change in focus from the use of public dollars to provide behavioral health services that meet a humanitarian and safety need to a more narrow focus on fiscal viability? (Minkoff 1997).

The Recovery Era (Since 2000)

Since the beginning of the twenty-first century, we have been in the Recovery Era and it is distinct from the Community Development Era in several ways. As discussed in detail in Chap. 7, recovery itself is an important organizing theme or big idea that challenges individual consumers, professionals, and stakeholders to think beyond mental illness symptom resolution to living a hopeful, purposeful, and meaningful life. The beginning of the millennium also is associated with several prominent health and mental health policy developments particularly at the federal level. Parity and the healthcare reform strategies of the 111th US Congress and of President Obama's Administration that were put forward in the Patient Protection and Accountable Care Act (ACA) (HealthCare.gov 2012) in 2010 capture and codify ambitious ideas that are likely to influence American health policy in the foreseeable future. The full impact of the ideas and policy direction of the Recovery Era is not known, but the stage is set for a new era in community behavioral health services. This era will likely be characterized not so much as one of expansion and new frontiers so much as consolidation and focusing of services so that effective treatment that promotes recovery is coordinated, individualized, and aligned with a person's needs at a point in time.

President George W. Bush Administration's report of the New Freedom Commission clearly supported goals of recovery for all Americans with mental illness (New Freedom Commission Report 2003). A central aspect of the Recovery Era is the existence of engaged and empowered consumers who are challenged to assume responsibility for the management of their illnesses and lives. This paradigm shift imparts on professionals and services the expectation that they support and challenge each patient to be the best that they can be.

In the current phase of the Recovery Era, through Medicare, Medicaid, and the Medicaid-expanded service for children (Children's Health Insurance Plan or CHIP), CMS will finance services to over one third of the US population or about 105 million Americans and will have beneficiary expenditures of over 800 billion dollars (CMS Budget Report to Congress, FY 2012). Ongoing awareness of the cost to maintain these two large government-financed healthcare programs has resulted in intense debate about the role of these government programs nationally. Current policy terminology includes the hope that mechanisms can be introduced that will decrease the rate of rise in healthcare costs, particularly in Medicare and Medicaid.

Parity is an important foundation for mental health services financing in the Recovery Era. Parity for mental health services was enacted in Congress originally in 1996 as the Mental Health Parity Act (MHPA) and was refined and reinforced with the Mental Health Parity and Addictions Equity Act (MHPEA) in October of 2008. Parity has been refined and carried forward as a cornerstone of the Obama Administration's health reform policy. The original federal MHPA parity law eliminated lifetime limits on mental health dollars and inpatient number of days and services. The MHPEA of 2008 states that health insurance benefits and the management of those benefits for persons with mental illness and substance abuse can be *no more restrictive than* the benefits provided for general health. An important refinement is the clarification that substance abuse treatment is included as a benefit to be covered at parity with mental and general health. The federal parity act was supported by principles associated with the Americans with Disabilities Act (ADA) that was enacted in 1990 (ada.gov 2012). The ADA provides protection from discrimination based on a disability to individuals in public settings, public programs, and in employment. Furthermore, until the Olmstead decision of the Supreme Court in 1999, there was not a

clear precedent that mental conditions were included as a disability condition under ADA. Olmstead clearly established the precedent that individuals with mental disabilities are included as a disabled group and have ADA protection from discrimination on a par with all disability groups in public programs, public settings, and in the workplace. Although most states had previously passed parity laws that applied to the operation of state insurance programs before the 2008 MHPEA, these were based on the earlier 1996 parity laws and had not been uniformly enforced and regulated. Parity is an important milestone in the financing of behavioral health services and sets the stage for a number of mental healthcare reform initiatives.

The subsequent Patient Protection and Affordable Care Act (ACA) included several features that will influence behavioral healthcare financing. A significant component of the ACA decreases the number of uninsured Americans through the broadening of Medicaid eligibility, federal subsidy of premiums, and increased availability of affordable insurance. Persons with mental illness are overrepresented in uninsured populations and this is likely to increase demand for behavioral health services. A foundation of the ACA includes demonstration projects that encourage experiments with bundled funding for a range of services that are to be better coordinated and more specifically tracked and actively case-managed. This is intended to increase experience with a move away from individual-oriented FFSs reimbursement and toward more of a capitated style of funding to a provider entity such as a primary care practice or hospital system that is accountable for providing and managing a range of services to the individual patients served by that entity. Incentives in this type of financial model would encourage healthcare provider organizations to promote increased access to lower cost services that are preventive in nature and conceptually would prevent or limit a downstream need for higher cost services.

Earlier in this chapter's discussion regarding state Medicaid arrangements with managed behavioral health companies, three types of relationships were presented: full risk wherein the managed care company assumes full financial risk for a population and also stands to profit if costs are kept low; limited risk wherein potential loss and profit are restricted for the behavioral health-managed care company; and no-risk, in which the managed care company provides administrative services only. This general style of payment is also present in several initiatives within the ACA to finance bundled care payments to health entities for the total management of an episode of care. An example of an episode of treatment might include an acute myocardial infarction (AMI) with all related hospital and professional fees including intensive care, diagnostic procedures, and outpatient rehabilitation being bundled together into a single payment. In this example, if the cardiology service fails to identify depression as a complication of the AMI and the person requires readmission for treatment of depression or has an unnecessarily protracted course the hospital might lose funding, on the other hand, early identification and treatment of depression could shorten the course, reduce total cost, and result in better overall outcome or the patient. In a general sense, the concept of *bundling* a payment is designed to promote efficiency and coordination of resources and expenses within a provider organization or hospital so that incentives for multiple individual fees are diminished. Bundling is a kind of limited risk relationship which provides incentives for cost management within an episode of care. Bundling of payments to provider entities is one of the big ideas in current Recovery Era healthcare reform that may shape financing for the immediate future.

A second and related financing model being undertaken in association with the ACA is financing for accountable care entities. The concept of an accountable care entity, also known as a healthcare "integrator," is seen with several demonstration projects, particularly in Medicare. *Accountable Care Organizations* are hospitals or groups of providers who assume responsibility for medical care for a population. *Health Homes* are primary care-oriented entities that provide coordinated care to a group of patients. Payment structures for this service are varied, but typically are based on three elements: a *case rate* for all or

qualifying high-risk members of the population of patients, FFS, and opportunities for performance-based incentives. A case rate is a form of capitation, with a set periodic payment that is typically gauged on the basis of risk for utilization of services, particularly unplanned high cost services. As of this writing, the full potential of these models for CBHO financing is not known, although many organizations have had experience with the administration of some of these models. An example would include the ways case management is funded, which typically includes a case rate for a given minimal number of encounters per month.

Medicaid and Medicare in the Recovery Era

Medicaid is currently the predominant funding source for mental health services. For many reasons, including healthcare reform provisions that enable a broader income range to be eligible for Medicaid, the state of the general economy so that more people are unemployed or underemployed and are Medicaid-eligible, and diminishing capacity of some local governments to fund local government grants for CBHO services, the proportional role of Medicaid is likely to continue to increase. Most of the provisions that expand Medicaid are financed by the federal government. Additionally, the ACA proposes to increase the FMAP for Medicaid in many states, particularly those with high unemployment rates so that the federal share is greater than it had been.

Medicare is a program with a growing number of aging baby-boomer beneficiaries. There are two significant initiatives within Medicare in the Recovery Era that impact CBHO financing. Medicare Part D, the prescription drug benefit, was initiated in 2003 in the Bush Administration's Medicare Modernization Act. This benefit was added in order to provide financial relief for Medicare recipients who had high costs for medication. Medicare beneficiaries that choose to participate select a plan from among a variety of prescription benefit plans that compete for enrollees. The programs establish competitive premiums and a competitive formulary to attract beneficiaries. Because of the provision that Medicaid must be the payer of last resort, all adults who are dually eligible must obtain medication through a Medicare D plan and not Medicaid. With the Medicare D plan, the pharmaceutical cost incurred by dually eligible individuals has shifted from Medicaid to Medicare. Some CBHOs provide psychiatric medications to patients and are at risk for the costs. The increased complexity in using the Medicare D benefit for psychiatric medications is difficult for many and often requires CBHO staff time to facilitate access to medications.

The second major initiative within Medicare in the recovery era that impacts CBHO financing is the range of demonstration financing models, as discussed earlier in association with the ACA. There is a general trend toward bundled payment plans and away from simple independent FFS payments.

Although the Mental Health Block Grant overall is currently not a large funding component for CBHO services, the Substance Abuse Prevention and Treatment Block Grant or SAPTBG does provide substantial dollars to substance use disorder treatment providers. CBHOs may or may not provide Mental health and substance abuse services. In 2011, the federal Substance Abuse and Mental Health Services Administration, the agency that administers these two block grants, announced its intention to merge these grants into one. Highly expanded block granting continues to be debated in policy and political circles. As recently as with the George W. Bush administration's Fiscal Year 2005 budget (Finegold 2004), and again in the congressional budget hearings for the FY 2011 federal budget, the proposal to allow states to convert their entire current Medicaid program into a block grant program was proposed. The advantage to a state would be increased flexibility of states to manage all funds because a state would no longer have to meet federal Medicaid requirements. However, the block grant design would effectively eliminate the legal entitlement that eligible individuals have with Medicaid services. With conversion of the entire Medicaid system as it is known now to a block grant

mechanism, governments, including federal and state, would have increased ability to control and predict costs. Given the predominance of Medicaid in financing CBHO services, any changes to Medicaid would have tremendous impact on CBHOs.

Another distinct method of financing services that has been used is service user *self management* or *self-directed care* (Alakeson 2008). In these arrangements, service users may be given an allowance to purchase their healthcare needs, choosing the provider who offers the best services or the types of services desired. In some arrangements, a person may choose alternatives to traditional services such as the payment of fees to participate in a community weight management program in lieu of an ongoing support group at a CBHO. This arrangement often offers consumers choices that they otherwise could not afford.

Conclusion and Summary

The funding of contemporary community mental health services is complex. It is comprised of multiple sources with different rules that render the funding mechanisms difficult to sort out at the clinical level in a CBHO. Mental health services have played a significant medical, humanitarian, and public safety role in American communities for well over 200 years in American history. Over time, funding sources for services have shifted from predominantly local government to state government and now more to our federal government. Too often, funding is seen as a barrier to the provision of ideal services to individuals with serious mental illnesses. It is critical for community psychiatrists to have a basic understanding of the major categories of funding and the general rules that govern access to these funds. Whether in CBHOs leadership positions or as line clinicians, having this understanding is a requirement to effectively advocate within systems for patients—both on individual and population-based scales. The basic information on funding sources in this chapter is intended to provide a background and orientation to help develop further understanding and utility of funding at the service level.

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6 Advocacy: The Push and Pull of Psychiatrists

Jeffrey Geller

In the area of mental illness, advocacy has been neither a unitary concept nor a simple activity. The methods by which individuals and groups advocate in general are many and have been largely consistent through American history (after accounting for changes in technology). Methods of advocacy by those treating, suffering from, or caring about mental illness show a distinct evolution:

> If the insane are sick people, and the asylum a judicial hospital, make it more and more possible for the insane patient to have early treatment and early discharge (Stephen Smith, M.D., NY State, Commissioner in Lunacy 1883).

> A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement (Joint Commission on Mental Illness and Health 1961).

> There is not one institutional psychiatrist alive who … could not be arraigned and convicted of extortion, mayhem and murder (L. Ron Hubbard 1969).

> After 200 years of working to improve conditions for the mentally ill, American psychiatrists must not abandon their advocate role either to the legal profession or to consumer groups, nor renounce their obligation as physicians to treat the whole patient within the context of his clinical and legal rights (Louis E. Kopolow, MD, NIMH 1977).

> Legal advocates for the mentally ill have not been willing to consider seriously the needs of the mentally ill and to formulate those needs as legal rights. Instead, they have done the reverse. They have treated rights as if they constituted the needs of the mentally ill (Alan A. Stone, MD, President of APA 1979).

> [In the 1970s, ex-patients] began to recognize a pattern they referred to as "mentalism" and "sane chauvinism" a set of assumptions which most people seemed to hold about mental patients: that they were incompetent, unable to do things for themselves, constantly in need of supervision and assistance, unpredictable, likely to be violent or irrational and so forth (Judy Chamberlain, National Empowerment Center 1990).

> Propelled by consumerism, the once marginalized ex-patient self-help alternatives, developed as *political opposition to* the mental health system, became institutionalized as consumer options within that system (Althena Helen McLean 2000).

> Advocacy is not just calling on others to do what we want; it is shining a light for others to follow (Steven S. Sharfstein, MD, President of APA 2006).

This chapter will examine who advocates, what they advocate for, the methods they use, and what the outcome has been across the history of psychiatry in the USA. Advocacy in Canada that has particularly interacted with or influenced the USA is included. Following this is a discussion of some current practices that are the subject of contemporary advocacy.

Who Advocates?

Since the first asylum in America was opened about 240 years ago, there have been three distinct cohorts of advocates: professionals, persons with

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mental illnesses, and families of patients with mental illnesses. Each of their voices has been of different strengths at different times, as has been the respect for and responsiveness to their advocacy. Thus, in 1881, Orpheu Everts wrote:

> Men and women of intellectual and social distinction who may have themselves (unhappily) suffered the humiliation, and possibly some errors, of hospital treatment, after apparently recovering the use of their faculties, have given tone and color of veracity to stories of ill-usage, and vigorous expression to mental concepts of hospital administration, tinged by memories and imaginations, the morbid parentage of which may be unsuspected by others or even by themselves (Everts 1881).

And in 1883, John Chapin opined:

> It is a common occurrence that managers of sensational newspapers, pandering to a morbid appetite for wretched personalities, admit to their columns without hesitation the most improbable statements of persons who have been inmates of asylums for insane… Discharged patients and employees, persons with real or supposed grievances, or disaffected from various causes have been ready to join together or act singly to bring about legislative investigations of asylums (Chapin 1883a).

Today, the voice of the former or current patient is heard quite differently.

The three cohorts of advocates might have included a fourth, namely attorneys. Attorneys as a force were actually organized and funded by the US Department of Health and Human Services on a state-by-state basis as of 1986 (Sundram 1995). This was a culmination of efforts born in the 1960s (Freddolino and Appelbaum 1984). But attorneys, while potent forces of advocacy in these matters, represent one or more of the other three cohorts and so are not considered a separate cohort in this chapter.

The major impediments to effective advocacy for improved care, treatment, community opportunities (work, housing, social integration), and interpretation of rights have been:

- The lack of cooperation, which can deteriorate to antagonism and hostility, between the cohorts of advocates, i.e., professional, patient, family.
- The infighting within a cohort, e.g., between psychiatrist and psychologist, between patient for and against psychotropic medication, and among family members for and against involuntary medications for outpatients.

Table 6.1 Who advocates and what do they advocate for?

Psychiatrist
Advocacy for profession
Scope of practice
Licensing and professional description
Work conditions: Environment (safety, support services), caseload, productivity, supervision
Remuneration
Advocacy for patients
Rights
Entitlements (monthly check, housing, health insurance)
Disability criteria
Employment
Adequate treatment (available, accessible, evidence-based, best practice)
Persons with mental illnesses
Self-advocacy on individual basis for individual rights
Advocacy as a group/movement for class rights
Advocacy around treatment
Receive treatment
Refuse treatment
Advocacy for nondiscrimination
Services
Housing
Employment
Citizen rights
Family members
Advocacy for treatment
With consent
Over objection
Advocacy for access to information
Patient and psychiatrist and family
Adequacy of services
Protection of rights
Equitable health insurance
Societal integration
End stigma
Government
Municipal/county
Mayor (or other city/town/county executive)
Sheriff
Police
State
State mental health authority
Other state agencies: Department of corrections, department of children services
Judiciary: judges, attorneys
Law enforcement: probation, state troopers, corrections officers
Federal
Congress
Executive Branch: President; Department of Justice; SAMHSA, NIMH, NIDA

Table 6.1 delineates who the advocates are and what they advocate for. Unless, and until, various cohorts can advocate with a unitary voice, and different cohorts can join forces to rally

Table 6.2 Methods of advocacy

Psychiatry
Professional organization, e.g., APA, AACP
Lobbying, e.g., political action committee, paid lobbyist, advocacy day
Constituent contact, e.g., letters to individual's Senators
Education, e.g., publication (hard copy, electronic)
Electronic list serve
Phone bank
Professional meeting
Survey
Persons with mental illness
Consumer movements
Protests
Legislative change, e.g., letter writing/e-mail campaign
Publications, e.g., Newsletter
Paid positions, e.g., consumer advocate, peer specialist
Surveys
Self-help groups
Testimonials
Family
Family organizations
Rallies, marches
Constituent pressure
Testimonials
Psychiatry, persons with mental illness, family
Join committee in another group's organization
Educate each other
Joint education of public
Joint lobbying
Colocation for shared work
Voices of individuals with membership in more than one group, e.g., prosumer
Joint testimonial

together around specific issues, advocacy for mental health matters will be significantly hampered. When different groups speak at cross-purposes, this provides cover for those who don't want to address the matter, like some legislators who can take no position by indicating, "I couldn't figure out what 'they' wanted" or "nothing I could do would please them."

Methods of Advocacy

The three cohorts of advocates—professional, patient, family—use a variety of advocacy methods. All groups use all methods, but the mainstay of each group's armamentarium of advocacy tools is different. Professions emphasize lobbying through professional organizations which often have a paid lobbyist. Consumer groups utilize rallies and protests, even disrupting professional meetings—a move often directed at the wrong decision makers since healthcare professionals do not make laws. Families organize to educate and lobby policymakers themselves.

The methods of advocacy are outlined in Table 6.2. Worthy of emphasis is that joint advocacy is the most effective advocacy. An excellent example of the results of joint advocacy is the inclusion of persons with mental illness into higher-level positions within state mental health authorities (Geller et al. 1998).

The use of different methods of advocacy has tended to exaggerate the differences in agendas. That is, they make differences in opinion seem much greater than they may be. For example, the street protests to ban all "shock treatment" (http://www.mindfreedom.org/kb/mental-health-abuse/electroshock) and the APA's efforts to produce guidelines for efficacious use of electroconvulsive treatment (ECT) (Weiner 2001) meant the two groups could not sit down to talk.

History of Advocacy for, by, and about Persons with Mental Illness

It is not possible to understand contemporary advocacy by, for, and about persons with mental illness without being knowledgeable about the history of these endeavors. The Appendix at the end of this chapter provides key points. In reviewing the Appendix, note how often the agendas of the three cohorts of advocates have overlapped, and how much of the time the outcomes pleased all or none of the cohorts. There are clear points where the methods and/or outcomes were not uniformly endorsed, but the surprise is how often they were.

Advocacy at the Beginning of the Twenty-First Century

This section examines issues around which there is strong advocacy in the first decade of the twenty-first century. Topics to be covered are

- Recovery
- Empowerment
- Treatment and treatment resources
- Involuntary or coercive treatment
- Employment
- Housing

A question might be posed as to why "stigma" is not a topic in its own right in this chapter. The reason is that stigma permeates through all the topics, and advocacy that results in fundamental, sustainable change in each of these topics will significantly decrease stigma. Stigma will wane to the point of being imperceptible, not when persons with serious mental illness are just like people without serious mental illness, but when both groups have the same opportunities to participate in every facet of the society in which they live. Paolo del Vecchio describes "hegemonic stigma and discrimination." He proclaims, "stigma and discrimination and recovery are inexorably linked: no justice, no recovery" (del Vecchio 2006a).

Recovery

Recovery, probably the fundamental concept in contemporary advocacy, is not a new principle in American psychiatry. The American "lunatic asylums" were founded on the principle of recovery. Psychiatrists (then called "alienists") did not run these asylums to provide lifelong care, and Dorothea Dix did not advocate to state legislative bodies and the US Congress for domiciliary care for the insane. Rather, all were focused on the removal of the suffering individual from the sources of stress (families, work) to healing environment (asylum) where the knowledgeable, beneficent superintendent could cure the individual and return him/her back to his/her community. The earlier the treatment occurred, the greater the likelihood of recovery. It was Pliny Earle, Superintendent of the asylum in Northampton, Massachusetts, who burst this bubble by documenting the fallacies in the superintendent's statistics (Earle 1887). As late as the 1880s, superintendents and commissioners were still talking about recovery (Smith 1883; Chapin 1883a).

The principle of recovery was lost to American psychiatry from the end of the 1880s to the end of World War II as the size of state hospital populations—made up of people with mental illnesses, with neurosyphilis, who were elderly, or who simply had nowhere else to go—exploded. Recovery efforts made a brief appearance in the 1950s as evidenced by scores of articles in the pages of the journal *Hospital and Community Psychiatry* of that era. The focus on hospital-based recovery was quickly lost, however, as just getting patients out of the hospital became the clarion call of an era retrospectively labeled "deinstitutionalization."

The rebirth of recovery is largely due to a few consumers, a few prosumers (advocates who are mental health professionals and have serious mental illness), and a professional or two. These individuals advocated for recovery to become the guiding principle of mental health reform predominantly through education, publications, speeches, mentoring, and modeling. Those in the vanguard include Judy Chamberlin of the National Empowerment Center (Chamberlin 1995), Dan Fisher, MD, PhD of the National Empowerment Center (Fisher 1994), Pat Deegan, PhD of the Institute for the Study of Human Resilience (Deegan 1988), Fred Frese, PhD of the Northeastern Ohio Universities College of Medicines (Frese et al. 2001), and William Anthony, PhD, of the Center for Psychiatric Rehabilitation. Anthony's was the most stentorian voice coming from someone not self-identified as being or having been a person with serious mental illness (Anthony 2000).

Professionals who were not past or present users of psychiatric services for serious mental illnesses (SMI) followed. Larry Davidson, PhD and his colleagues at Yale write prolifically about recovery (Davidson et al. 2006). The American Psychiatric Association adopted a position statement on recovery in July 2005 (American Psychiatric Association 2005), and the American Association of Community Psychiatrists had one in 2001 (AACP Guidelines for Recovery Oriented Services 2001). Recovery started to become integrated into psychiatric training, initially in public sector fellowships

(Ranz and Mancini 2008). And recovery became the focus of research with investigators starting to study specific methods of recovery (Cook et al. 2009).

Recovery, then, is an example where advocacy, initiated largely by those with psychiatric histories along with a few maverick professionals, and directed at professionals and policymakers, has both transformed the contemporary practice of psychiatry and returned the practice of psychiatry to its roots.

Empowerment

There is no recovery without empowerment, but the goal of empowerment is more complicated and fractious than simply a component of recovery. Advocacy for empowerment has meant different things to different people and has been the keystone in the consumer movement.

For some, empowerment means freeing oneself from all the shackles of psychiatry—with shackles being all there is in organized psychiatry. Thus, Leonard Frank wrote,

> We of the psychiatric inmate's liberation movement affirm the statement that the policies and practices of American psychiatry are oppressive… [we are] human beings whose lives psychiatry has damaged, whose lives psychiatry has ruined, whose lives psychiatry has shortened, and whose lives psychiatry has taken… The roots of psychiatric authority are fraud, fear and force, psychiatry's unholy trinity (Frank 1986).

For some, the effort is not so much directed *against* psychiatry, as it is *towards* freedom. As Chamberlin said, "Wanting to be free is not a delusion"—nor is not wanting to be *defined* by a psychiatric diagnosis (Chamberlin 1997a).

Chamberlin (1997b) and Fisher (1994) have each defined empowerment, in highly useful terms. In Fisher's definition, empowerment embodies hope, personhood, achievement of self-defined goals, choices, the opportunity to speak for ourselves, peer support, an end to discrimination, self-control of symptoms, well-being, liberty and freedom, healing from within (Fisher 1994). To actualize empowerment, Fisher advocates for (1) facilitating recovery through education and inspiration of hope, (2) developing alternatives to hospitalization, (3) providing state funding of involuntary admission under the public safety budget rather than the healthcare budget, (4) maximizing survivor and consumer involvement in all aspects of treatment, (5) establishing self-help and consumer-run services, (6) ensuring that survivors and consumers are genuinely and effectively involved in the protection of human rights and the improvement of quality of services, (7) favoring the role of personal care attendants rather than case managers, (8) viewing the life experiences of recovery from a serious psychiatric disability as an asset in hiring, not a liability, (9) promoting consumer control and choice of access to housing and financial, educational, vocational, and social services, (10) providing staff training based on the needs of survivors and consumers, and (11) basing total quality improvement of mental health services on outcome measures designed by survivors and consumers (Fisher 1994).

That doesn't sound all that radical. In fact, del Vecchio makes the point that "today's consumer movement is not 'radical'" (del Vecchio 2006b). He points out that "rather than fighting against pharmacological treatment the movement supports the consumer's choice of treatments—including medications—and is often active in promoting increased funding for mental health funding…" (del Vecchio 2006b).

While the patients'/ex-patients' voices for empowerment have been loud, organized psychiatry has consistently advocated for patients' empowerment, although neither as unambivalently nor as articulately as some with SMI. For example, in 1896, John Chapin, MD, of the Pennsylvania Hospital stressed that "patients lose none of their civil rights when they enter the door of his institution" (Chapin 1896). In 1981, Richard Lamb strenuously advocated for "securing patients' rights responsibly" (Lamb 1981). And lest we not forget, it was George Brooks, superintendent of Vermont State Hospital, who started the work (subsequently picked up by Courtenay Harding (Brooks and Deane 1965; Harding et al. 1987) to show that schizophrenia was not, of its absolute nature, a progressively

disabling condition leaving the person a powerless victim.

For the psychiatrist practicing in the community, advocacy for empowerment of the patients one sees is not so much done on a soap box as it is every day in one's office, in an apartment, on a street corner, or wherever one provides services to a patient. The psychiatrist has the capacity to empower the patient by the very nature of shared decision-making in doctor–patient interactions. That is grassroots advocacy. In working with the patient as partner, psychiatrists and psychiatric patients will lead the rest of medicine, as we appear to be doing. Medicine is just now coming to patient empowerment in what the American Medical Association is calling "participatory medicine" (Moyer 2010).

Treatment and Treatment Resources

Advocacy concerning treatment has two facets: advocacy for the right to treatment and advocacy for the right to refuse treatment. Ironically, there has been greater success with the right to refuse than the right to get treatment.

Repeatedly, the US Supreme Court has failed to find a constitutional right to treatment. However, for inpatients, various entities such as the federal Center for Medicare and Medicaid Services, The Joint Commission, and the US Department of Justice have set minimal standards for treatment. On the outpatient side, there appears to be more attention to increasing productivity: more patients per hour, rather than the quality of the treatment a patient receives. Police are becoming providers of psychiatric services as resources dwindle at community mental health centers (Zezima 2010). No matter where one is on the advocacy spectrum, all should advocate for good quality services that are accessible and affordable, accountable and respectful, and delivered in a partnership between patient and practitioner.

The health reforms that have addressed parity (Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008) and insurability (The Patient Protection and Affordable Care Act 2010) set a platform, but do not guarantee any aspect of quality mental health services. It is here that advocacy needs to be strong and continuous. It can be disheartening to realize that one is hard-pressed to find any mental health reform that was clearly acknowledged, at its outset, to improve treatment and cost more money. At a time when mental health services were quite poorly funded, the President's New Freedom Commission's mandate was to be cost neutral (Hogan 2003).

The right to refuse treatment has really been a movement for the right to refuse treatment when one has the capacity to refuse and the right to have some procedure to override refusal after a procedure to determine the individual is not competent to consent or refuse. At this point in time, both psychiatrists and patients endorse this principle. These practices vary state to state, with the trend towards court involvement.

Another issue requiring the advocacy of patients, former patients, families, and practitioner is that of manpower. The need to train a workforce to meet the needs of those with SMI is long-standing. In 1947, Harris and Otto observed: It has been our conviction for a great many years that there existed a critical need for more undergraduate training in psychiatry designed primarily to equip the general practitioner to deal more adequately with the very types of psychiatric disorders that ordinarily do not require care in a psychopathic hospital (Harris and Otto 1947).

Little has changed. Coordinated advocacy among all interested parties is what is needed. On a basic level, one avenue of advocacy for effective treatment interventions is informed by the finding that greater involvement of patients in their own treatment (Freddolino et al. 1989) produces better outcomes. Through greater involvement, there is confluence of treatment, empowerment, employment, and recovery. Finally, an area of new collaborative advocacy is the integration of psychiatry and medicine. The morbidity and mortality of SMI, compounded by psychotropic medication (Felker et al. 1996), needs to drive the advocacy in this arena.

Involuntary/Coercive Treatment

Perhaps the most devise issue among the three cohorts of advocates is that of involuntary/coercive treatment. Advocacy and "counter-advocacy" have played out in the areas of

- Hospitalization
- Medication
- Seclusion and restraint
- Community treatment

While these issues all sound quite contemporary, many are long-standing quandaries.

On the matter of involuntary hospitalization, Kraepelin wrote at the turn of the twentieth century, "Does the general attempt to bring about better care of our insane by placing them in institutions represent a practical philanthropy and is it a healthy sign of our social life? In other words, should one aid or oppose this movement?" (Kraepelin 1900).

The matter of seclusion and restraint was considered at the first meeting of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII) (forerunner of the APA): "At its first meeting, the Association, by resolutions expressing its unanimous sense, declared its position manfully regarding a question which has perhaps provoked more animated and sometimes acrimonious controversy, than any other connected with the management of the insane, holding as it did, that the true interests of the insane forbade the abandonment of all means of personal restraint in the treatment" (Callender 1883).

The members of the AMSAII were quite aware that this position was not going to be popular with restraint abolitionists. They rather poetically indicated, "The clamor for the institution of so-called reform in the total abolition of restraint, incited in mingled ignorance and malevolence, has vented much objurgation against this position of the Association" (Callender 1883).

In most cases where the chemical restraints are now used in American hospitals, I have no hesitation in saying that they are far preferable to the vigilance or force of attendants. The object is gained more surely, more effectually, and with far less annoyance to the patient. A mechanical contrivance performs its office steadily, uniformly, and thoroughly and is submitted to as something inevitable. The will and strength of an attendant are capricious and variable in their operation. It is objected to mechanical restraints that they leave disagreeable impressions on the mind of the patient who regards them, even after recovery, as marks of degradation and kindness. That such feelings may have been observed in patients whose recovery was quite imperfect, and who consequently regarded restraints, as they might a thousand other things, in a very false light, is very probable, but not a single instance of such feeling has come to my knowledge, in patients who had attained healthy views on every other subject. It is also objected to them that they are liable to be abused; that they are often applied to save trouble, and even to gratify the light of attendants… It is our rule to use no more, and continue it no longer, than is necessary to affect the object in view, and in all cases, it is the comfort of the patient, not the attendant, which is consulted (Anonymous 1845).

The modern resurrection of the seclusion and restraint debate owes a great deal to the efforts of the federal Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA has called for the elimination of seclusion and restraint (Curie 2005). It should be noted that seclusion and restraint are two distinct procedures, used separately and never simultaneously. SAMHSA advocates for a "transformation of the system of care" and for recovery and posits that the elimination of seclusion and restraint is fundamental to a culture shift. But even SAMHSA equivocates: "seclusion and restraint must be used only when the potential exists for imminent physical danger to the patient or others" (Curie 2005). SAMHSA then offers guidelines for the use of seclusion and restraint that many view as unworkable, e.g., "physical restraint may not exceed 10 min."

Advocacy against involuntary medication has been conducted under the banners of "the right to refuse treatment" and "nothing about us without us" (see section "Treatment and Treatment Resources"). Advocacy for involuntary treatment

has long argued against, "rotting with their rights on."

Perhaps the hottest subject for advocacy on both sides of the treatment issue over the past decade has been the use of involuntary treatment in the community, otherwise known as outpatient commitment or assisted outpatient treatment (AOT). While there is a history of involuntary or coercive community-based treatment throughout the twentieth century when hundreds and hundreds of individuals were placed on "visit status" from state hospitals (still legally patients of the hospital, but allowed to live in the community), the modern era of advocacy, for and against involuntary outpatient treatment really began in the 1980s (Geller 1986). The most potent advocacy organization in favor of involuntary community treatment has been the Treatment Advocacy Center (http://www.treatmentadvocacycenter.org) led by E. Fuller Torrey (http://www.treatmentadvocacycenter.org/index.php?option =com_content&task=view&id=16&Itemid=45). Opponents of involuntary community treatment have been led by attorney-advocates, e.g., Bazelon Center (http://www.bazelon.org), Center for Public Representation (http://www.centerforpublicrep.org). Both sides have used studies to bolster their arguments (Honig and Stefan 2005; Geller and Stanley 2005).

Issues under the heading of voluntary only vs. involuntary only when necessary have not only divided the three cohorts of advocates, but also have split each group. Psychiatrists against any involuntary treatments are exemplified by Thomas Szasz (http://www.szasz.com). The Board of the Treatment Advocacy Center counts consumers among its members (http://www.treatmentadvocacycenter.org). To effectively take a position on the issues of involuntary vs. voluntary interventions, one must thoroughly review the data and form one's own conclusions. Do you believe anosognosia is a valid and significant symptom? (Gilleen et al. 2010). Does the AOT law in New York State (Kendra's Law) work due to the coercive components, or simply because patients under AOT get more community resources? (Phelan et al. 2010). Will outpatient commitment widen the net of involuntariness? (Geller et al. 2006).

Once informed, one is then in a position to advocate, for or against.

Housing

It is hard to imagine anyone is going to be against housing for persons with SMI. Who would be in favor of homelessness? Should be a simple matter and we can all advocate together, right? Turns out it is not so simple.

Advocating to end homelessness was generally straightforward and was the predominant housing issue of the 1980s (Lamb 1992). Providing better housing for persons who already had room and board in psychiatric facilities proved to be more complex. In order to advocate for appropriate housing, one needs to understand "supportive housing," "supported housing," "assertive community treatment" (ACT), "housing first," "permanent vs. transitional housing," etc. One needs to be familiar with requirements of the ADA, the *Olmstead* case, Medicaid, etc. Then one needs to apply this knowledge to questions like,

- Are the assumptions made by the US Supreme Court in the *Olmstead* case clinically valid?
- Does Housing First, designed for homeless, substance-abusing individuals work equally well for a person with SMI?
- What models of housing in a state would be a "fundamental alteration" of services as defined by ADA?
- Is it true that all (or most) individuals with SMI in institutions, if provided information they understood about housing options, would choose supported housing and actually move forward with relocating?
- When are the costs of relocating and supporting one specific individual in the community so high that they interfere with actually performing the same tasks for several other individuals?

With answers, one is prepared to advocate for the housing options one endorses. Being

prepared, there needs to be actual advocacy using the methods described earlier in this chapter.

Employment

Employment is another area where there is general agreement among the three cohorts of advocacy: employment is an important part of recovery and highly beneficial for the individual's sense of well-being. Employment of persons with mental illness has a long and evolutionary history. In the nineteenth century, asylum patients worked for two basic reasons: work was beneficial to patient's recovery and the asylum could not function without patient labor. Through the first half of the twentieth century, patients worked simply to keep the state hospital, with its 1,000–15,000 patients, operational. In the 1950s, state hospitals established programs aimed at equipping patients for work in the community (see *Hospital and Community Psychiatry* throughout the 1950s). This focus was lost with "deinstitutionalization"(see above).

The agenda voiced by advocates since the late 1980s has been that of getting persons into the mainstream work force. (There were isolated efforts to this end earlier such as Fountain House and the clubhouse movement). This agenda has been augmented by advocacy efforts initially coming from patients and ex-patients to achieve employment in the mental health field (i.e., peer support/peer survivor positions).

About 75–85% of those aged 18- to 65-year-old in the USA are employed, while the percentage of those with mental illness who are employed is 50–60% of that. About 20% of those with schizophrenia/schizoaffective disorders work. Further, about 60% of those without mental illness work full-time, while only 33% of those with mental illness do (Mechanic et al. 2002). There is considerable room for improvement and this area is ripe for advocacy directed at creating adequately funded programs to get those with SMI into the workforce. Advocacy aimed at competitive work for those with mental illness has been bolstered by studies demonstrating the effectiveness of efforts to achieve this objective, such as studies of supported employment (Drake et al. 1999). Advocacy efforts are almost always assisted by evidence-based findings.

Peer Support

Peer support can be described as consisting of six categories: peer-delivered services, peer employees, peer-run and operated services, peer partnerships, self-help groups, and Internet support groups (Solomon 2004). Those that are directed at work have been shown to be beneficial in many ways. For example, peer-provided services have been found to be as effective as nonpeer-provided services (Solomon 2004). Peer services have benefited the mental health system in many ways: direct labor cost-savings, decreased hospitalization, shorter hospital stays, getting outpatient services to those who would not avail themselves of traditional services, and wellness benefits to both the giver and the receiver of the services (Geller et al. 1998).

Peer services are an example of where different groups may advocate for the same end, but for very different reasons. Patients/ex-patients may advocate for peer services as a keystone to recovery. Mental health administrators may advocate for peer services as a significant labor force cost reduction paying lip service to recovery. One way to keep the two groups on the same track is to have patients/ex-patients working in state mental health authorities (Solomon 2004).

An important lesson from this area of advocacy is that advocacy by different subgroups for the same outcome may be motivated by very different considerations, e.g., wellness vs. cost saving. While the outcome may be achieved, the differences concerning ultimate goals will eventually lead to the deterioration of joint advocacy and the potential loss of any gains. The ultimate purpose of any advocacy effort needs to be clear to all parties involved in that effort (Geller et al. 1998).

Conclusion

The state of advocacy for causes related to mental illness at the beginning of the twenty-first century is well articulated by David Mechanic:

Too often I've seen excellent scientists and well-informed clinicians undermine the value of their knowledge and their positive influence with patients through inattention to the power of empathic communication. Second, I've learned that popular ideas that seem intuitively correct and seductive are often wrong and sometimes are harmful… I am impressed that mental health advocates too often talk primarily to one another and to those already committed to their positions… Too often, enthusiastic hype far exceeds real advances or the likelihood of tangible help in the foreseeable future, a problem that characterizes advocacy for biomedical science—and indeed all science—in the American political context. We would be well served by being more humble in our claims and accepting that we still know relatively little about causes, processes, cures, or even good management of the major mental illnesses (Mechanic et al. 2002).

In advocacy on behalf of persons with SMI, we perpetually revisit issues as if they had never been considered before. Note these nineteenth century comments:

> The asylums, instead of being regarded as hospitals and asylums for the medical treatment of a disordered condition, have come to be regarded as objects of suspicion; as convenient places for the "incarceration" of persons by designing relatives, and lunatic prisons, proper only for the detention of the criminal and dangerous insane (Chapin 1883b).

> As to the laws relating to the commitment of the insane, it must be borne in mind the asylum management does not make them, although a contrary impression sometimes seems to prevail, but is mainly concerned in carefully executing those that may be enacted by competent authority (Chapin 1883b).

> We need have no fears of public sentiment if we take the pains of educating the public. The public will trust us if we trust it, show it what we are doing—and why we do so. There are a great many things that take place in our hospitals that have no parallel in institutions, the population of which are sane. Yet the public holds us responsible for conduct, and results, based upon estimates, leaving insanity, as an element, entirely out. If the whole truth were known about our institutions, we would have no trouble at all (Anonymous 1885).

> We desire to say here, and in behalf of the insane themselves to impress upon all *doctrinaires* and public agitators upon this subject, that the most obvious right of the insane in any state of society where private life is respected, and the peace of the domestic fireside is held sacred, is the right not to be meddled with and annoyed one jot more than is necessary (italics in original) (Rights of the Insane 1883).

If advocacy is going to be both different from, and more effective than, in the past, disparate interest groups are going to have to work together. There are obvious challenges in doing so, as different groups of advocates work primarily from different ethical perspectives: patient autonomy, medical paternalism, and role integrity (Eth et al. 1984). Even among groups often considered aligned, sprouts of difference can uproot fields of agreement.

Disagreements among mental health advocacy groups facilitate nonaction by people advocates need to act on their interests. Thus, when different advocacy groups visit a Congressman's office and advocate at cross-purposes, it becomes easy for the Congressman to say he has no position on the issue (personal experience, Robert Wood Johnson Health Policy Fellow 1994).

As we join together in the partnerships of collaborative advocacy, we need to remember our task is of yeomen proportion:

> Adopting an advocacy role means vigorously challenging the status quo. It means not accepting the unrealistic limitations that government agencies place on resources for the poor and other vulnerable segments of society. It means rejecting political expediency that might lead to short-term financial gain. It means convincing the power establishment that preventive services are cost-effective. And it means challenging quiescent peers to join in advocacy efforts (DeFries 1993).

Appendix: Historical appendix

Advocacy timeline	
1842	Elizabeth T. Stone publishes, *A Sketch of the Life of Elizabeth T. Stone* describing the deprivation of her liberty when hospitalized at McLean Asylum
1844	Thirteen superintendents (from the then existing 24 public and private mental hospitals) meet in Philadelphia and form The Association of Medical Superintendents of American Institutions for the Insane. In 1921, the association changed its name to The American Psychiatric Association (APA)
1849	Dorothea Dix visits the East Cambridge, Massachusetts jail and finds insane prisoners confined under inhumane conditions
1851–1860	Patients of Utica State Lunatic Asylum publish a periodical, *OPAL*
1866	Elizabeth Packard publishes her first book *Martial Power Exemplified*; 3 years earlier, she founded the Anti-Insane Asylum Society (Illinois)
1880	Formation of the National Association for the Protection of the Insane. The reasons for this Association included: increase in the types of diseases of the nervous system; increase in the incidence of insanity; "the peculiar helplessness of the insane"; help bring about central government supervision in all states; raising the standard of treatment in and out of asylums; and obtain and diffuse knowledge about insanity
1892	Charlotte Perkins Gilman publishes *The Yellow Wallpaper*, a fictionalized account of her treatment by S. Weir Mitchell's rest cure
1908	Clifford Beers publishes his autobiography, *A Mind That Found Itself*. In 1919, with funding from the Commonwealth Fund and the Rockefeller Foundation, Beers forms the International Committee for Mental Hygiene (ICMH), the forerunner of the World Federation for Mental Health (WFMH) (1948)
1909	Beers founds the National Committee for Mental Hygiene, renamed Mental Health Association in 1976, National Mental Health Association in 1980, and Mental Health America in 2006
1930	May 5–10. First International Congress on Mental Hygiene (Washington, DC)
1935	June 10 is considered the founding date of Alcoholics Anonymous (AA)
1937	Recovery, Inc. is founded by Neuropsychiatrist, Abraham Low (Chicago)
Mid 1940s	Patients at Rockland State Hospital (NY) form We Are Not Alone which morphs into Fountain House
1946	Mary Jane Ward publishes *The Snake Pit*
1948	Albert Deutsch publishes *The Shame of the States (Mental illness and social policy: the American experience)* describing conditions in state mental hospitals
1949	Passage of the National Mental Health Act (PL 79-87) leads to the establishment of the National Institute of Mental Health (NIMH) as one component of the National Institute of Health
1951	NIMH publishes *The Draft Act Governing Hospitalization of the Mentally Ill*
1952	The APA publishes its first *Diagnostic and Statistical Manual of Mental Diseases (DSM I)*
1955	Formation of the Joint Commission on Mental Illness and Health
1956	Inception of the Social Security Disability Insurance (SSDI) program Passage of the Health Amendments Act of 1956 (PL 84-911) paves the way for the passage of comprehensive community mental health center legislation
1960	Thomas Szasz publishes "The Myth of Mental Illness" in the *American Psychologist*. A year later he publishes a book with the same title
1961	Erving Goffman publishes *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*
	A US Senate investigates and publishes its findings on Constitutional Rights of the Mentally Ill
1962	Ken Kesey publishes *One Flew Over the Cuckoo's Nest*
1963	Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (PL 88-164). Bill contains funding for constructing community mental health center (CMHCs), but no funds for staffing them
1964	*Dixon v. Weinberger* (District Court of the District of Columbia) finds patients at St. Elizabeth's Hospital have a statutory right to treatment and that those involuntarily committed must be placed in the least restrictive setting consistent with suitable treatment
1965	Medicare legislation is passed. It includes limited coverage for patients receiving active treatment in state hospitals in addition to those in general hospitals

(continued)

Advocacy timeline	
1966	The Social Security Amendments of 1965 (PL 89-97) adds Title XIX, Medicaid, to the Social Security Act
	Lake v. Cameron. An individual cannot be committed until hospital officials determined there is no less restrictive facility available to care for that individual
	Rouse v. Cameron. Criminal defendant who is acquitted by reason of insanity and involuntarily committed to a psychiatric hospital has a legally enforceable right to adequate and suitable treatment
1970	Insane Liberation Front is formed by Dorothy Weiner, Tom Wittick, and others (OR)
	April. The first issue of *The Radical Therapist* is published
	Wyatt v. Stickney. Three fundamental conditions are necessary for adequate and effective treatment in public psychiatric hospitals: a humane psychological and physical environment, enough qualified staff to administer adequate treatment and individualized treatment plans
1971	Mental Patient Liberation Project (New York) is founded with one of its creators being well known advocate, Howie the Harp (Howard Geld). The Mental Patients Liberation Front is founded in Boston
	Mental Patients' Association is founded in Vancouver, Canada. Almost immediately MPA begins operating a drop-in center and community residence. The USA lagged beyond the Canadian consumer-run services model by 5–10 years
	Soteria Research Project, founded by psychiatrist Loren Mosher opens its first house. Soteria is an early model of client-centered, recovery-based treatment with minimal use of antipsychotic medications
1972	A group of former mental patients circulate a newsletter, *Madness Network News*
	Bruce Ennis, a staff attorney with the ACLU (NY) publishes, *Prisoners of Psychiatry* exposing extralegal uses of psychiatry
	Founding of the Mental Health Law Project, subsequently known as of 1993 as the Judge David L. Bazelon Center for Mental Health Law, aka Bazelon Center
	Lessard v. Schmidt. Persons facing involuntary civil commitment are guaranteed the full array of procedural safeguards formerly guaranteed only to individuals charged with a crime
	A US district court judge in the District of Columbia orders an outpatient commitment
1973	An APA Committee passes a resolution that homosexuality per se should not be considered a psychiatric disorder
	First conference on Human Rights and Psychiatric Oppression
	The North American Conference for Human Rights and Against Psychiatric Oppression holds its first Annual Meeting
	Souder v. Brennan. Patient-workers are entitled to minimum wages and overtime compensation, thus ending most state hospital work programs
1974	The book *The Madness Network News Reader* is published by former mental patients and anti-psychiatry activists
1975	*Donaldson v. O'Connor.* A person who is involuntarily civilly committed to a psychiatric hospital has a constitutional right "to such treatment as will help him be cured or to improve his mental condition"
	Roger v. Okin. The first class-action suit on the right to refuse treatment
1977	Mental Patients' Rights Association founded by Sally Zinman (Florida)
	NIMH initiates the Community Support Programs (CSP) to address problems created by poorly executed removal of long-term state hospital patients from their institutions. NIMH awards contracts to 16 states under CSP
	President Carter signs an executive order creating the President's Commission on Mental Health
	The General Accounting Office publishes the first governmental study of the problems of deinstitutionalization, called *Returning the Mentally Disabled to the Community: Government Needs to Do More*
1978	Judy Chamberlin publishes *On Our Own: Patient Controlled Alternatives to the Mental Health System*
	President Carter's Commission on Mental Health publishes *Report to the President*
	Leonard Roy Frank edits and publishes *The History of Shock Treatment*
	First CSP Learning Conference

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Advocacy timeline	
1979	September. Almost 300 people attended a conference on advocacy for persons with chronic mental illness sponsored by the Dane County Alliance for the Mentally Ill and the University of Wisconsin-Extension in Madison, WI. This conference spurns the birth of the National Alliance on Mental Illness (NAMI)
	Community Support System (CSS) is formed growing out of a series of meetings at NIMH. Components of a CSS were identified as treatment, rehabilitation, case management, basic support, enrichment, crisis intervention, self-help, and rights protection
	Addington v. Texas. The minimum standard of proof to be met in civil commitment hearings is "clear and convincing evidence"
1980	"Phoenix Rising: The Voice of the Psychiatrized" began publication by former psychiatric inpatients (Canada)
	Suzuki v. Yuen. Involuntary civil commitment solely on the grounds of danger to property is unconstitutional
	The Civil Rights of Institutionalized Persons Act allows the federal government to initiate actions against states whose public institutions-such as hospitals, prisons, nursing homes and jails-deny residents their constitutional rights
	The Social Security Amendments of 1980 (PL 96-265) mandate review of all Social Security Disability Insurance (SSDI) beneficiaries, except those determined to be permanently disabled, once every 3 years
	The Mental Health Systems Act, the major accomplishment in mental health of the Carter administration, creates a comprehensive federal-state effort to care for persons with mental illness
	Surgeon General Julius B. Richmond, M.D., releases *Toward a National Plan for the Chronically Mentally Ill*
1981	*Pennhurst State School and Hospital v. Halderman.* Court denies that a federal statute had established a right to treatment for persons with developmental disabilities
	US Supreme Court rules inpatients of public psychiatric institutions are not eligible for Supplemental Security Income (SSI) payments granted to persons with mental illness
	The Omnibus Budget Reconciliation Act (OBRA) of 1981 eviscerates the Mental Health Systems Act. The Act lumps together all remaining categorical mental health programs into a huge block grant
1982	Founding of the Carter Center
	Mills v. Rogers. US Supreme Court does not decide on a constitutional right to treatment
	Youngberg v. Romeo. A person in an institution has a constitutionally guaranteed "right to personal security," "a right to freedom from bodily restraint," and the right to receive "such training as an appropriate professional would consider reasonable to ensure his safety and to facilitate his ability to function free from bodily restraints." The effect is to narrowly define any constitutional "right to treatment"
	May 14–18. At the tenth annual International Conference on Human Rights and Psychiatric Oppression (Toronto, Canada) participants promulgated a set of 30 principles
	November 2. Berkeley, CA voters pass a referendum banning electroconvulsive therapy within the city
1983	May. The California Department of Mental Health, through its Community Support System Project, funds the development of the Consumer Steering Committee
	Academic Consortium is founded to advocate for expanded federal research dollars for mental illness
1984	The Disability Benefit Reform Act of 1984 requires the Social Security Administration to develop new health criteria for disability determination

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Advocacy timeline	
1985	NAMI forms a subgroup called NAMI Client Council, renamed NAMI Consumer Council
	April. A consent decree is signed in a Maryland case, *Coe v. Hughes* that establishes that indigent patients in the 12 public inpatient psychiatric facilities have a right to access to the judicial system
	June. The First National Mental Health Consumers' Conference is held in Baltimore, MD
	Formation of the National Depressive and Manic Depressive Association (NDMDA), subsequently the Depressive and Bipolar Support Alliance (DBSA), a patient-directed national organization focused on advocacy, outreach, and education
	American Association of Community Psychiatrists (AACP) is founded. The mission of AACP is to encourage, equip, and empower community and public psychiatrists to develop and implement policies and high-quality practices that promote individuals, family, and community resilience and recovery
	US Senate Subcommittee on the Handicapped issues a report of its investigation of conditions in psychiatric institutions, documenting lack of treatment, abuse, neglect, exploitation, deplorable living conditions throughout the USA. The Subcommittee chair proclaims, "Protection for these frailest of our society exists largely on paper"
1986	National Mental Health Consumers' Self-Help Clearing House is founded by Joseph Rogers
	Public Law 99-319 creates a protection and advocacy system for persons with mental illness
	The State Comprehensive Mental Health Services Plan Act (PL99-660) calls on each state to prepare a detailed plan for the care of persons with severe mental illnesses. The plan's development was to include participation by consumers, families, and advocates
1987	*Board of Nassau County v. Arline.* "Society's accumulated myths and fears about disease are as handicapping as the physical limitations"
1988	Formation of Support Coalition International, which subsequently became Mind Freedom
	Shrink-Resistant: The Struggle Against Psychiatry in Canada, edited by Don Weitz and Bonnie Burstow, is published
1989	November 23–26. Canada's first national conference for survivors of psychiatric "services" is attended by about 200 psychiatric survivors
1990	Spring/Summer. *The Journal of Mind and Behavior* publishes an issue, "Challenging the therapeutic state; critical perspectives on psychiatry and the mental health system" with contributor including Phyllis Chesler, Andrew Scull, Peter Breggin, Leonard Frank, Judi Chamberlin, and Thomas Szasz
	Medicaid expands to include a case management option and redefines rehabilitation to include psychiatric rehabilitation services
	The Americans with Disabilities Act (ADA) is enacted to eliminate discrimination against disabled persons. Title II says, "No qualified individual with a disability, shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"
1991	Formation of the World Federation of Psychiatric Users (WFPU), later to become the World Network of Users and Survivors of Psychiatry (WNUSP) (International), now a consultant organization to the United Nations
	United Nations adopts Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
	The Inspector General of the General Accounting Office concludes that NIMH needs to address the findings of "blatant" noncompliance among a fourth of the CMHCs reviewed in the scope and volume of services provided to those unable to pay for them
	The Patient Self-Determination Act, part of the Omnibus Budget and Reconciliation Act of 1990, requires healthcare facilities that receive Medicare and Medicaid funding to provide information to adult patients about their right to make their own healthcare decisions, including the right to accept or refuse treatment and to execute advance directives about medical care

(continued)

Advocacy timeline	
1992	Center for Mental Health Services (CMHS) is formed within the Substance Abuse and Mental Health Services Administration (SAMHSA)
	National Empowerment Center is formed by cofounders Daniel B. Fisher, M.D., Ph.D. and Patricia E. Deegan, Ph.D., both of whom were diagnosed with schizophrenia
	A group of consumers, who are also researchers, initiate the Consumer/Survivor Research and Policy Workgroup. This group works to redefine the national mental health agenda through collaboration with mental health professionals and policy makers
1996	The Domenici-Wellstone Illness Parity Amendment means that businesses with more than 50 employees will have to offer health insurance plans with equal annual and lifetime limits for mental and physical illnesses
	Public Law 104-21 prohibits payment of SSDI and SSI benefits to persons whose disability is based on drug addiction or alcoholism
1997	*Kansas v. Hendricks.* Sex offenders can be civilly committed
	Charles Q. v. Houston (Pennsylvania). State psychiatric hospital patients with the dual diagnoses of mental illness and mental retardation can be served in the community
1988	*Kathleen S. v. Department of Public Welfare* (Pennsylvania). Under the ADA, former patients of the former Haverford State Hospital have a right to placement in the most integrated setting appropriate for their needs
1999	December. Release of the first Surgeon General's report on mental health
	Olmstead v. L.C. and E.W. The ADA requires states to provide community placement for persons with mental disabilities if the state's treatment professionals have determined it is appropriate, if it is not opposed by the individuals affected, and if it can reasonably be provided considering state resources and the needs of other disabled persons
	First White House Conference on Mental Health
2000	Ticket to Work and Work Improvement Act increases level of income disabled persons can earn before losing Medicaid and extends period of time an individual can work and continue to receive Medicare
	President Clinton signs a bill authorizing $10 million for mental health courts over four years
2001	February 1. President George W. Bush announces the New Freedom Initiative, a broad plan to provide $5 billion over five years to help Americans with disabilities become better integrated into communities and workplaces
	Released as a supplement to the 1999 report, the Surgeon General's report, *Mental Health: Culture, Race and Ethnicity* documents a disproportionately high burden of disability from mental illness among African Americans, American Indians, Asian Americans, and Hispanic Americans
2002	*Toyota Motor Manufacturing, Kentucky, Inc. v. Williams.* ADA must be strictly interpreted to limit the number of people who can qualify as disabled
	November. Release of *the Interim Report of the President's New Freedom Commission on Mental Health*. Report highlights five areas 1. Fragmentation and gaps in care for children 2. Same for adults 3. High unemployment and disability for people with mental illness 4. Older adults with mental illness are not receiving treatment 5. Mental health and suicide prevention are not national priorities

(continued)

Advocacy timeline	
2003	Formation of the Coalition Against Psychiatric Assault (CAPA), a Toronto (Canada)-based organization whose members are "committed to dismantling the psychiatric system", "see the very concept of mental illness as flawed," and "oppose the violation of human rights which is endemic to psychiatry"
	May: President's New Freedom Commission submits *Achieving the Promise: Transforming Mental Health Care*. Released by the White House in July, the report suggests six goals and recommendations for a transformed mental health system 1. Americans understand that mental health is essential to overall health 2. Mental health care is consumer- and family-driven 3. Disparities in mental health services are eliminated 4. Early mental health screening, assessment, and referral are common practice 5. Excellent mental health care is delivered and research is accelerated, and 6. Technology is used to access mental health care and information Passage of Medicare Prescription Drug, Improvement and Modernization Act of 2003 introduces Medicare Part D with an implementation date of 2006
2005	APA honors Dorothea Dix with its first Posthumous Fellowship
	APA launches HealthyMinds.org, a consumer-oriented website to educate the public about mental health resources and treatment
	Institute of Medicine (IOM) publishes, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*
2006	NAMI publishes, *Grading the States: A Report Card on America's Health Care System for Seniors Mental Illness*. Nationally, the grade was D. No state received an A and only five states obtained a B
	From Study to Action: A Strategic Plan for Transformation of Mental Health Care sets out *models* for understanding and organizing transformative systems change
	Roadmap to Seclusion and Restraint Free Mental Health Services emphasizes culture change within organizations as the fundamental change to reducing restrictive interventions
	DBSA publishes a workbook to help individuals set goals for their recovery: *Next Steps: Getting the Treatment You Need to Reach Real Recovery*
	Mental health consumer-survivors form a national coalition of organizations run by consumers, representing 28 states and the District of Columbia, to ensure they have a major role in the development and implementation of national and state policies
2008	March 5. US House of Representatives passes H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. This legislation expands the 1996 Mental Health Parity Act. The Senate had previously passed S.558, Mental Health Parity Act of 2007
	May 3. Enactment by the United Nations of "The Convention of the Rights of Persons with Disabilities"
	July 9. US Senate joins US House of Representatives in voting to end discriminatory copay for psychiatric outpatient visits by passing the Medicare Improvements for Patients and Providers Act. Coinsurance differential to be phased out by 2014
	October 3. President Obama signs the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008. The effective date of the law is January 1, 2010
	US Congress overturns Supreme Court decisions that narrowed the applicability of the ADA by the ADA Amendments Act
	President Bush signs the Genetic Information Nondiscrimination Act of 2008 which prohibits discrimination by insurers and employers due to genetic makeup or family history
	SAMHSA publishes, *Self Disclosure and Its Impact on People Who Receive Mental Health Services*
2010	March 1. The decision in *DAI v. Patterson* means that the 4,000 residents of New York State adult homes of 120 or more beds are qualified to live in supported housing. NYS is ordered to create 1500 supported housing units per year for 3 years. The state must employ peer bridgers to assist in the process
	March 23. President Obama signs the Patient Protection and Affordable Care Act with an implementation time line from 2010 to 2014

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7 Recovery and Person-Centered Care: Empowerment, Collaboration, and Integration

Wesley E. Sowers

Introduction

The concept of recovery is not a new one in behavioral health, but it has experienced resurgence since the release of the President's New Freedom Commission report in 2003 (Hogan 2003). The belief that persons with mental illness or substance use disorders can lead productive and satisfying lives has been part of the philosophic core of community psychiatry for many years and was practiced most notably in psychiatric rehabilitation paradigms through the latter part of the twentieth century. While variations on the theme of recovery have been noted since the nineteenth century and perhaps even earlier, they were established more formally in the 1930s with the establishment of the Alcoholics Anonymous and Recovery, Inc. (Sowers 2003).

Brief Historical Perspective

The idea of recovery has been a mainstay of the addiction community for many years. It has its roots in the 12-step movement that began in the 1930s (White 1998). It became clear to the founders of Alcoholics Anonymous that overcoming the disease of addiction was much more than establishing abstinence. They recognized that addictive disorders create thought processes and conditioned responses that are far more powerful than the physiological manifestations of dependence. They offered an alternative to professional offerings that appeared to be more effective (Laudet et al. 2000). The 12 steps and the various slogans related to thought processes common in persons with addictions are all related to current concepts about recovery.

Although recovery has had a less prominent role in the mental health community in the past, it has been part of the scene for nearly as long as it has been part of the addiction field. Abraham Low, MD, a psychiatrist, began developing recovery-enhancing techniques in 1937, and by 1952, Recovery, Inc was established (Lowe 1950; Sachs 1997). Recovery, Inc. is an organization run by Mental Health consumers that employs many of the ideas developed by Dr. Low. It offers a peer-assisted healing program that focuses on changing thought processes, developing autonomy, and regaining productive and satisfying lives. Like the 12-step approach, it attempts to empower people to take responsibility for managing their illness or disability. In contrast to 12-step programs, Recovery, Inc. has incorporated the value of developing a partnership with helping professionals and has attempted to support this relationship (Sowers 2003).

An anti-psychiatry movement, originated within the profession in the later part of the twentieth century, questioning the controlling and judgmental nature of common practices. The legitimacy of

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diagnosis was also questioned, in light of the lack of biologic or etiologic explanation for them as in other branches of medicine. Who should define "normal" experience? These threads were expanded by "survivors" of treatment who also saw psychiatry as being controlling and oppressive, and psychiatrists were generally vilified in some circles such as Scientology. RD Laing and Thomas Szasz were psychiatrists who were among the original critics of the profession and social constructs of mental illness, but they were not critical of treatment per se, so long as people were interested in receiving it. However, as the movement evolved, it began to ostracize those who sought and participated in treatment, depicting them as brainwashed. These controversies continue today as diagnostic systems evolve (Rissmiller and Rissmiller 2006).

There are many people with mental illness or substance use disorders who have felt that they have been mistreated by the system and they have become more organized and more vocal in recent years regarding their rights as individuals, their conviction that they must control their own destiny, and that they should not be oppressed by authorities whose primary interests are control and public safety. The "Recovery Movement" has emerged from these convictions, and while it is not necessarily a unified movement, it has become a significant political force impacting policy and practice in the administration of behavioral health services. Persons in "recovery" have asserted that systems of care and professional attitudes must change if they are hoping to engage with them. Only then will they find meaningful assistance in their struggle to attain autonomy and meaning in their lives (Borkin 2000).

System transformation has emerged as a major priority in federal and state behavioral health services administrations since the issue of the President's New Freedom Commission Report and the Surgeon General's report on mental health issues (SAMHSA 2003; U.S. Department of Health and Human Services 1999). Penetration to policy makers and administrators has been fairly broad, but much work remains to be done with regard to training and actual practice (Jacobson and Curtis 2000). The movements mentioned above have been progenitors of the current emphasis on "social inclusion" and securing the civil rights of persons with behavioral health disorders and have significant impact on the evolution of services today. This "transformation" aims to replace a system that has been described as prescriptive and paternalistic with one that is collaborative, empowering, and recognizes the potential for growth and change in the individuals that it serves. While there are few that oppose this transformation in principle, there are many who feel the obstacles to achieving the ideal are too formidable to overcome and that is not applicable to everyone who suffers these maladies.

This chapter will consider the nature of recovery and resiliency and their usefulness as organizing concepts in the evolution of our systems of care. It will examine the principles and practices which may be most helpful in moving people toward recovery and the value of incorporating them into the way that services are delivered.

The Elements of Recovery

The concept of recovery has a long history as noted earlier, but it is not a monolithic one, and there have been many variations in how persons or groups have defined it. If recovery is an individual experience as most contend, then each person who has experienced it may define it somewhat differently. Even though recovery has individual meanings and is a dynamic concept, there are certain elements that can be identified that are commonly included in the definitions and that remain fairly stable through changing circumstances (Whitley and Drake 2010). This section will attempt to identify some of those common elements and consider their significance (SAMHSA 2005).

The term "recovery" implies that a person, who has been disabled for some period of time, returns to their previous level of function, but it has come to take on a much broader significance with regard to persons with behavioral health disorders. There are many who feel that the term is inadequate because in many cases people have not ever developed good capability and are working toward establishing it for the first time. This is especially true for children with emotional disturbances. Another objection is the implication that there is an end point, or cure. This point

remains controversial, and there are many who claim that recovery, even from severe mental illness, may be complete, while others contend that it is an ongoing process, which, for most people, is lifelong.

Whichever position is adopted, being "in" recovery, as opposed to being "recovered" describes a process. As various aspects of this process are considered, it may be of interest to consider how they mirror other theories of development, mature coping strategies, and self-actualization. Even though the idea of recovery has been applied most commonly to situations in which a person is struggling to overcome an identifiable (or diagnosable) condition, in its most basic sense, recovery is about a growth and maturation process, not distinct from what all people must negotiate at some time in their lives (Erikson 1950; Vogel-Scibilia et al. 2009). As such, it can be considered a developmental process leading to a "mature" state of being (Mead and Copeland 2000).

By contrast, people who do not engage in a recovery process often appear to be "stuck" in a cycle of making the same decisions over and over, despite the fact that they are not happy with the results. Most of us experience this state at some time in our lives or in some aspect of our living and find that we are afraid of uncertainty and the possibility that we could be even unhappier if we choose to do something unfamiliar. This state will be referred to as "Stagnation" for the purposes of our discussion.

The Aims of a Recovery Process

Change

A person enters a recovery process as an attempt to break patterns of behavior that have been detrimental to their well-being. There are almost always choices that can be made about how to think and act regardless of what type of limitations or disabilities with which one is confronted. Change must often be radical in order to escape the rigidity of past patterns of behavior, and "reinventing oneself" is a challenging and daunting prospect.

Growth

Change leads to growth, to an expanding sense of self and of the world. A growth or maturation process begins when one is able to embrace change and continues in an incremental fashion as new experiences and behaviors are added to an individual's palette. A state of stagnation implies a closed world of repetition circumscribed around sets of stereotyped behaviors. Recovery, in contrast, implies expanding world, new possibilities, and customized responses to the significant challenges presented by a changing environment (Deegan 1988).

Autonomy and Resilience

Growth and the development of a broader array of behaviors allow people to adapt to a wide variety of circumstances. Adaptability and the capacity to influence the environment lead to a greater sense of personal effectiveness. The way that one understands their reality changes from one in which they believe that they have no control over or responsibility for what happens to them, to one in which they believe that the choices that they make and things they do are the most important determinants of their experience and circumstance. As the process of recovery progresses, there is a growing capacity to act independently and to make responsible decisions (Mead et al. 2001).

Purpose and Meaning

Ultimately, satisfaction in life must be derived from the ideas and activities that give it meaning. We derive meaning from a number of sources: spiritual connections, work, relationships, social structures, education, recreation, and artistic endeavors (King 2004; Green et al. 1997). As growth progresses and we see ourselves as the agents that shape our world, we begin to create a set of beliefs to replace a nihilistic void that characterizes a stagnant life.

Development of Enabling Qualities

In order to initiate and sustain a recovery process, a person must develop several qualities to enable it. These may be described in various ways, but however they are conceived; there is an evolution in the thinking process as people progress toward the changes they wish to make. Many of these qualities are included in various formulations of stages of change. The most common of these elements will be presented here as a progression, but in reality, they do not always appear in a linear or predictable chronologic order.

Acceptance and Responsibility

Before a desire to change can take hold, a person must recognize their limitations and/or disabilities. While there is often tremendous tenacity in resistance to admitting vulnerability, and to giving up the belief that factors outside one's self are responsible for one's trouble, once it is surmounted, there is a possibility for change. With acceptance comes responsibility, the recognition that we must depend on ourselves to do what is required to make changes.

Desire and Determination

In order for change to occur, people must move beyond ambivalence and even willingness, and develop a genuine desire to live differently and a determination to do whatever is needed to do so.

Hope and Faith

When people are stuck and stagnant, they are often unable to see that things can be any different and feel helpless to change their circumstances. When a person decides to enter a recovery process they are embracing the possibility of change and they must develop the belief that they are capable of it.

Courage, Diligence, and Tolerance

Change requires intense and consistent effort and causes a great deal of discomfort and pain. A person must find the courage to face/experience this challenge and the tenacity to persevere under physical and emotional stress.

Integrity, Honesty, and Trust

A person engaging in a recovery process is most successful when able to consistently pursue and represent the truth and judicious values and avoid misrepresentation and deception. Achieving this, it is possible to gain respect and trust in oneself and from others. These qualities make it possible to join a community and find meaning beyond immediate self-interests.

Tolerance, Humility, and Forgiveness

To be human is to make mistakes; sometimes they may be egregious mistakes that cause a great deal of suffering. In order to progress in a recovery process, a person must develop some capacity to accept the weaknesses of others and to recognize their own. Freedom and equanimity come with the capacity to forgive both oneself and others.

Characteristics of a Mature Recovery

The development of the foregoing virtues is obviously an extended process which is likely to proceed in fits and starts and it may take many years to achieve great consistency. For most people, it is a lifelong struggle to stay on track. This process, when successfully negotiated, leads ultimately to a certain balance and satisfaction in life in which a person is also a reliable and trusted member of a community. As these qualities become more and more consistent, confidence grows, as does the ability to adapt to

and make changes. People find new ways to manage their lives and relationships, drawing on growing resources and a willingness to accept some of the risk that comes with self-disclosure and emotional investment. Openness to new ideas, self-observation and assessment, a capacity for kindness and empathy, thoughtfulness, and flexibility, and the realization that one need not denigrate others to value one's self would all be aspects of maturity in recovery, whether in mental health or with substance use disorders.

Resiliency and Recovery

As someone progresses with recovery, they become more resilient, or better able to cope with adversity (Unger 2011). These two concepts share many common elements, and they both imply an ability to thrive. They are generally used in different contexts. "Resiliency" is most often used by clinicians and other stakeholders when referring to the characteristics of children and adolescents. The negative implications of recovery, described earlier, are more significant for this age group. "Recovery," on the other hand, is more often used when referring to adult development but it is not easily separated from the resiliency concept. Many have commented on the inadequacy of the terminology, but it has not been easy to find broadly acceptable alternatives. While the two terms are similar, there are some qualities that distinguish them:

- Resiliency describes a *characteristic* or *state* that allows positive adaptation within the context of significant adversity. Each person has his or her own unique level of resilience.
- Recovery describes a *process* that allows restoration or renewal following personal setbacks related to disabling circumstances. Individuals may or may not engage in a recovery process.
- Resiliency is partly determined by one's genetic makeup, and partly developed through experience and environmental influences (i.e., nurturing vs. neglectful).
- Recovery is independent of biological determinants and is largely characterized by attitudes and values rather than abilities.
- Developing resiliency is an essential aspect of a successful recovery process.
- Resiliency may occur in the absence of a recovery process.

Universal Aspects of Recovery

Over the years, the definitions of recovery and what it represents have been variable, and different groups may conceive of it in different ways. This raises the question of whether recovery is the same for everyone, regardless of their affliction, or is it distinct for people recovering from a particular type of disability? Recovery may be defined narrowly or broadly. For example, recovery from an addiction might be conceived of as attaining abstinence or it may be defined more broadly as life satisfaction and growth. Likewise in mental health, recovery may be seen as the absence of symptoms and a reduction in the use of services, or alternatively as the ability to live autonomously and make healthy choices.

While there has been some controversy around who "owns" recovery and how it should be formulated, there is a growing consensus on the main elements that constitute a recovery process. This is fortunate, because it makes obvious sense to have a unified understanding of recovery, especially as we struggle to better integrate services for persons with behavioral health issues.

These elements of recovery provide a blueprint for change, regardless of individual circumstances. Whether someone has a mental illness, a substance use disorder, a physical disability, had a traumatic experience, or is simply struggling against patterns of behavior that make managing their daily lives difficult, the recipe for change is more or less the same. Although the degree of disability and the difficulty of engaging in a recovery process may vary considerably, recognizing that everyone must follow a common pathway to accomplish change has significant implications for clinical processes, service delivery, and social stigma.

The Value of the Recovery Paradigm

Recovery creates a framework for change that can be applied in a variety of circumstances and settings, so it provides a common language which all clinicians and service users can understand and use to promote health and wellness. As such, it can be the basis for integration of an often diverse array of providers that may be involved in a person's care (Mueser et al. 2002). In clinical settings, it can be the foundation for empathy and collaboration through its formulation of shared human emotions, experience, and ambition. In the broader community, its universal aspects form a strong weapon to wield against stigma. As the community comes to recognize the common experiences of all its constituents, it becomes the basis for acceptance and inclusion and the protection of every individual's human rights. Many observers have noted that the recovery movement is ultimately a civil rights struggle.

Developing Person-Centered, Recovery-Oriented Services

Having considered what constitutes a recovery process, we can now turn our attention to how psychiatrists and other clinicians can promote and facilitate recovery and how we can create services that support it. The development of Recovery-Oriented Services (ROS) begins with the recognition that services must be constructed to meet the needs of individuals and that individuals should not be expected to benefit from programs or treatments designed for stereotypic patients with preconceived needs (Anthony 2000). Person-Centered Care is sometimes used interchangeably with Recovery-Oriented Services, but may also be seen as an aspect of these services that particularly emphasize the key concept described above. The following principles provide further description of ROS:

- *Hopeful-optimistic*: The clinician's role is to inspire hope and create an atmosphere that assertively recognizes the possibility for change in every individual (Borkin 2000).
- *Respectful-strength based*: The attitude of service providers must be respectful and focused on the positive attributes that define an individual. They must be sensitive to and avoid the subtle condescension that has generally characterized paternalistic approaches of the past (Kaufmann et al. 1989).
- *Empowering*: ROS encourage service users to take control of their lives, accept responsibility for change, and use shared information to make informed choices (Fisher 1994).
- *Collaborative*: Treatment is conceived of as a partnership between the person seeking assistance and those offering care. Discarding the traditional roles of a controlling provider and a passive consumer, in this paradigm the two work as a team to accomplish the consumer's goals (Noordsy et al. 2000).
- *Supportive-nurturing*: Disabilities are destructive to self-esteem and confidence. Recovery is a progressive process and requires gradual fortification of these qualities through support, encouragement, recognition of achievements, and trust (Mead et al. 2001).
- *Capacitating*: Growth implies an expanding ability to live, learn, work, create, and interact. ROS should help every individual to define and reach their potential with regard to these activities (Carlson et al. 2001).
- *Inclusive*: ROS should offer and encourage inclusion of disabled individuals in all administrative processes that govern the operation of services. They will also encourage involvement in the larger community (Townsend et al. 2000).
- *Comprehensive*: People should have access to a complete array of clinical and supportive services to meet their basic needs as well as their emotional and spiritual needs. In the planning process, these services should be tailored to fit individual issues.
- *Outcome informed*: To make informed health choices, people must have access to information related to the likely results associated with available treatments. There should be opportunities for them to learn about outcomes and evidence, and how to evaluate them (Roberts 2002).
- *Culturally sensitive*: Individuals may have multiple cultural influences in their lives, including

spiritual concerns (Huguelet et al. 2011). ROS should celebrate diversity, explore cultural experience, and value the unique contributions that it makes to how one operates in the world and how people understand and experience a disability.

- *Integrated*: It may require several different providers to meet the needs of a particular person. ROS recognize the need to coordinate and, if possible, consolidate the services provided into a coherent and interactive plan with the consumer at its center.
- *Voluntary*: The use of seclusion, restraint, and coercion are not consistent with ROS and are only used if there are clearly no other alternatives. ROS recognize that individuals may have periods of incapacity and encourage the formulation of appropriate plans for these circumstances (Davis 2002).

A significant aspect of Person-Centered Care is its focus on *information sharing* and offering choices that are informed by that knowledge. It encourages individuals to formulate a personal vision for their lives and to create plans that will give them an opportunity to fulfill those ideals. The central role of the relationship in healing processes is also a critical aspect of Person-Centered Care and ROS. The *relationship-building* process is ultimately the source of trust that is essential for a clinical partnership. This partnership is what allows engagement in a collaborative planning process, which is the best guarantor of investment in the product of that process (Manfred-Gilham et al. 2002).

A focus on *health and wellness* as opposed to illness and disability is another hallmark of ROS. The prevention or the mitigation of relapse to active illness is accomplished by developing skills that facilitate making healthy choices and exercising effective health management. In this regard, it mirrors the *chronic care and disease management models* promulgated in physical health care. Recognition of the interaction of mental and physical processes as an important determinant of overall well-being leads to an *integrated or holistic approach to service delivery* which fits with recent concepts of medical/mental health homes, or centralized, coordinated care models (Beardslee et al. 2011). The great disparity in health status and life expectancy, between those with behavioral health issues and the general population, makes this aspect of recovery-oriented care ever more critical. Health cannot be subdivided into its components, as all aspects are interdependent. ROS recognize that people can be healthy, even with an active illness, just as they maybe unhealthy without identifiable disease.

Concerns are often raised about the applicability of ROS to persons with very severe mental illnesses who have periods of cognitive deficits rendering them unable to make prudent choices. They may consistently make choices that place them at risk of harm (Davidson et al. 2006). It is important to recall in these instances that recovery is a *developmental process*, and it is not always a linear one. We might think of "stages" of recovery as analogous to the stages of change often referred to in the addiction literature. Just as we would not offer a young child complete freedom to do as they please, we would not offer this to someone who has uncontrolled and severe symptoms of mental illness. The operating principle in cases where a person has diminished capacity is to gradually extend their capacity to make wise and responsible choices. Gradually increasing degrees of freedom and choice are required to accomplish this. In the most severe cases of mental illness and intellectual disability this may be a very slow process. The intention of ROS is to consistently attempt to extend an individual's capacity for self-management and self-agency. When this is not possible, the use of *advanced directives* can be a very valuable tool to allow individuals to exercise some control even when they are most debilitated (Srebnik et al. 2005; Henderson et al. 2008).

Finally, ROS must find ways to challenge individuals to recognize their own possibilities and to pursue their vision without creating overwhelming stress. Much of this work will be accomplished through motivational techniques, allowing individuals to gradually define their own needs, desires, and solutions. Rather than striving for compliance or adherence, ROS hope to create *investment* in a shared plan for change. Change is disruptive and frightening, calling many beliefs and practices into question. ROS

must be comfortable in helping people to confront and find answers to spiritual/existential questions; and it must help them to find ways to become part of a community and develop satisfying relationships with others.

Implementation and System Transformation

The characteristics described above provide a basic idea of the nature of services provided by organizations that wish to promote recovery. The American Association of Community Psychiatrists developed the *Guidelines for Recovery Oriented Services*. This document provides further elaborated description of ROS by delineating 17 separate characteristics, and dividing them into three categories: Administrative, treatment, and support. For each characteristic, a set of measurable indicators follows a descriptive paragraph. This document provides a "blueprint" for organizations that would like to develop this model. Its companion *Recovery Oriented Services Evaluation* (*ROSE*) is a self-assessment tool, which translates the indicators of the Guidelines into anchors in its rating process. While not validated, the use of this tool creates capacity to enable organizations to measure their progress in developing ROS over time. There have been several other tools that have become available recently, which provide similar guidance.

Several other issues will be encountered by organizations wishing to implement ROS in place of traditional practices. The existing behavioral health workforce has, for the most part, not been well trained to work in a collaborative, egalitarian manner with the people that they serve. As noted above, change is very difficult to embrace, and it is commonly experienced as a threat. Clinicians can often be resistant to change that is not self-initiated, or they may minimize differences between these proposed practices and those currently in place. Full implementation of ROS usually constitutes a cultural change, and it is very difficult to uproot established practices and attitudes.

In this context, it requires visionary or transformational leadership to move organizations toward person-centered, recovery-focused care (Corrigan and Garman 1999). Leaders and teachers will be most successful by taking a motivational approach, helping their staff to find incentives for and value in making changes to their practice. To do so, there must be a significant investment of time and energy to allow not only adequate information transfer but opportunities to process the information and its implications. Significant change occurs most readily when people see that it will further their own interests, so it will be important to help staff define what those interests are.

Leadership, in moving the organization toward ROS, has an opportunity to model facilitative and collaborative practices rather than directive, authoritarian methods. Transparency, informality, flexibility, and suggestibility all contribute to the empowerment of staff, and eventually contribute to their ability to treat their clients reciprocally. Solicitation of input and participation in administrative activities and program design and development also allow staff to feel invested in the organization and to take pride in its success. As one might expect, this idea of participation is one that facilitates clients' investment in a treatment planning process and adherence to the collaborative plan developed from it. Having this experience in the workplace begins to create a different culture and will make a translation to clinical processes much easier.

Nontraditional approaches to training may also help to overcome some of the resistance to change. One method that has been well received and successful is the promotion of dialogues between consumers and providers outside their usual roles in the clinical context. Fears about the consequences of honesty can be minimized if participants feel that they have no real life relationship with their counterparts. This arrangement allows a genuine sharing of experience both from the consumer and the Behavioral Health professional and is inevitably appreciated by the participants. It promotes empathy and trust, and helps participants to understand that they are less different from one another than they have imagined.

Creating a competent workforce for ROS is a long-term process, but can be expedited with

organizational commitment and consistency in applying the principles of ROS at all levels of the organization. Even with these conditions in place, there may be some individuals in the organization who do not feel comfortable with this new paradigm, and will want to leave. In most cases it is wise to facilitate these wishes, and accept the idea that not everyone is ready for change or well suited to work in this way.

Changing the content of professional training to incorporate the principles of ROS in both didactic and practical aspects of training will ensure that a new generation of clinicians becomes available to replace those leaving the workforce (Peebles et al. 2009). Although it may seem daunting to insert this new content into the already overcrowded curricula commonly encountered in psychiatric training programs, this is an overarching attitudinal shift that will not necessarily replace other topics, but instead should enhance them all. It will require commitment from academic institutions to implement these necessary changes in curricula and incentives are needed to facilitate have movement in this direction.

Evidence, Quality, and Recovery-Oriented Services

As discussed above, one of the important elements of ROS is to provide information to consumers and allow them to choose among available options based on what they have learned (Farkas et al. 2005). A full discussion of evidence-based practices is discussed elsewhere in this book, but it is important to state that the strength of evidence for the effectiveness of each available clinical option is an essential part of ROS.

But what is the evidence for the effectiveness of ROS? There is not yet a clear answer to that question. Many people believe that, intuitively, if people have more control over their care, they will be more invested and more likely to adhere to the plans that they have made to progress in their recovery. A variation of that theme is that ROS is not a "treatment," but provides a *context* and an *attitude* for the delivery of services. If ROS promote equality and justice for persons with behavioral health disorders, then the issue of "evidence" needs not be relevant.

Others note that ROS are complex and multifaceted and as a result, it would be extremely difficult to generate evidence for its effectiveness using standard approaches. Furthermore, if "recovery" is the desired outcome, then traditional measures of successful treatment may no longer be appropriate. This would apply equally to quality improvement processes. Indicators of success would be more closely aligned with consumer satisfaction and quality of life, rather than service needs and utilization (Drake et al. 2003). While evidence-informed interventions are an important element of ROS, the nature of "valid" evidence must be scrutinized, and perhaps broadened, to accurately reflect the benefits of these approaches (Torrey et al. 2005).

Recovery and ROS are recurrent themes throughout this text and the concepts presented here provide a foundation for thinking about the many implications these perspectives will have on the typical activities of the community psychiatrist. They inform our relationships with clients, our approach to service design and delivery, and the scope of our involvement in the community. As noted earlier, a recovery perspective has long been an aspect of good community psychiatry, and indeed, it is hard to imagine how it could be otherwise.

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Part III

The New: Emerging Keys to Practice

8 Inspiring a Welcoming, Hopeful Culture

Christie A. Cline and Kenneth Minkoff

Introduction: Welcoming, Hope, and the Vision of Community Psychiatry

Community psychiatry has unique values and a unique vision, which radically sets it apart from other behavioral health "disciplines." Community psychiatry provides a safety net service for a "community"—for a defined population that may need help with behavioral health issues of all kinds. This is critically important: as a safety net provider, anyone who is not "caught" in your net will not receive services anywhere. The consequences of not being engaged may be dire, and in fact, may be a matter of life and death. Consequently, the pride of community psychiatry is its capacity to be responsive to the needs of people and families—"customers"—who have serious needs and would not be able to receive services anywhere else. This responsibility extends not just to the "easy" customers, the ones who neatly fit into our existing service packages, but particularly to "complicated" customers, the ones who may not fit *at all*, and yet are desperate for help and hope.

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These values—a vision of hope and help for those most in need, whom *no one else will serve*—is what gives community psychiatry its true heart. Yet, the implementation of this set of values, the articulation of this vision in community psychiatric practice, programs, and settings is not a trivial matter. It requires deliberate attention, at every level of organization structure, process, program, and practice, to ensure that those most in need and that those most likely to be "misfits" in other settings are not only tolerated and accepted but also specifically and proactively *welcomed* for care—and inspired with the hope and promise of recovery—wherever, whenever, and however they present. Consider the following situation:

> Carlos is a 49-year-old Mexican man who has been referred to your community behavioral health program following his parole from state prison after serving 5 years of a 10-year sentence for an armed robbery to obtain drugs during a time when he was actively addicted to cocaine. Carlos has a 15-year history of schizoaffective disorder and has been receiving antipsychotic and mood stabilizing medication in prison. Under parole supervision, he lives in a residential program for individuals with mental illness in your community and is sent to your program for case management, medication, and rehabilitative services. Carlos used to work as a welder until his addiction to alcohol and cocaine, as well as persistent psychosis, caused him to lose his job. He has two children in their late teens that live with his ex-wife; she wants nothing to do with him. He has a large extended family that has maintained contact with him in prison. The family members care about Carlos, but do not want to provide him with any financial help or with a place to live. Carlos' primary language is Spanish; he

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speaks English with limited proficiency. He also is suffering from hepatitis C and is overweight.

Carlos came to his first appointment at your program 2 weeks ago, within a few days of his release from prison and moving into his residence. He had been given a 30-day supply of medication and did not need a refill. He had an initial appointment with a case manager, but was not very talkative about his symptoms, or his life. He seemed a little suspicious and said that his main goal was to not go back to prison. He wanted to try to get a job, and somehow be reconnected to his family. He said that he wanted to make sure to do what his parole officer wanted him to do. He also said that he did not like living in the group home, but "I guess I'm going to have to put up with it." He stated that he was committed to not using drugs, but did not like going to "those NA meetings." "I am strong; I have a lot of will power." "I don't really want a case manager; I am a man who can take care of himself." He said that he would come back for medications and was willing to get help with reinstating his disability.

This morning, Carlos appears, unscheduled, in your waiting room. He is disheveled, agitated, and reeking of alcohol. He states that he got kicked out of the residence last night and spent the night on the street. "They said I was drunk when I only had a few." "Those assholes were stealing my stuff, and I said I would get someone, but good, if they didn't cut it out." He is demanding to see his case manager immediately, saying that he needs a place to stay so he won't go back to prison.

Question: What should your clinic staff do first?

The Challenge of Welcoming

Given that this is a chapter on welcoming and hope, it is easy to see that "the right answer" to the question posed above would be "Welcome him!" It is also easy to see that welcoming him would be a significant challenge, clinically and organizationally.

On the one hand, the consequences for Carlos of not being welcomed, engaged, and inspired with hope in the middle of this major crisis could be catastrophic. The wrong approach could result in violence, involuntary commitment, homelessness, and/or reincarceration.

On the other hand, Carlos is exactly the kind of person that most staff at the program might experience as "impossible" to welcome. He is big, drunk, scary, potentially violent, and a parolee with a history of violence. He is also homeless, paranoid, and "behaving inappropriately." He does not even speak English very well.

Yet, if our values in the world of community behavioral health care involve holding ourselves to the *highest possible standard* for welcoming customers like Carlos, then we not only recognize welcoming him as a priority, but also deliberately organize welcoming, hopeful engagement, empowerment, and partnership for people like Carlos as a core customer-oriented, value-driven "business practice" for our entire agency.

What Would "Welcoming" Look Like in this Situation?

As soon as Carlos comes in the door, and it is clear that he is in crisis, the program (starting with the receptionist) needs to initiate an immediate response plan that makes it most likely that Carlos will have a successful experience and come away thinking that he made a very good decision to come to the clinic this morning.

The receptionist, seeing him come into the waiting room clearly agitated, would contact a person on duty available for immediate response. She might say: "Welcome Carlos. It looks like you need help immediately. I am calling someone to come and see you who should be out here in a few minutes. Would you like something to eat or drink?"

The on-duty clinical staff person would come out, explain that Carlos' regular case manager is not available at the moment, but that he or she is pleased to talk to Carlos. Then, the staff person might thank Carlos for coming in when he was in a crisis, and ask Carlos if he would mind going to an office to sit down and talk, as well as repeating the offer of something to eat or drink.

Once in the office, the clinician would recognize that Carlos is having a very hard time, is probably very scared and feeling out of control. Carlos needs to feel not only welcomed but empowered and respected. He needs to feel that we will treat him as a partner, not a victim. He needs to feel hope, rather than feel that what is left of his hope is being taken away. In order to reinforce that Carlos made a good decision

coming in, the clinician might say, looking Carlos right in the eyes:

> I want you to know that I am very impressed that you came into see us, since you hardly know us. Thank you for your trust. It's amazing that you had the courage to come in here. I don't know what happened, but it looks like a serious crisis. Let's sit down and talk, so you can tell me your story, and we can figure out together how to help you. The fact that you came for help is a wonderful thing. I know we want to do everything we can to help you to stay out of prison, and help you to achieve your goals.

This welcoming, hopeful approach would be the best chance to help Carlos to calm down and feel safe, rather than challenged, to take time to figure out a solution to his crisis, to get him through the next few hours, and to help him plan for some positive next steps to find housing and stay out of prison.

On the other hand, if Carlos is not proactively welcomed, it is highly likely that the situation could get much worse. It wouldn't be hard to think of a number of things that the staff could say to Carlos that would increase his chance of becoming *more* agitated, and even violent. Here are some common examples:

- You need to go to the emergency room right away. We can't help you here if you're like this.
- You can't just walk in and be seen on demand. You need to have an appointment.
- We have a rule that says that you can't be seen if you are intoxicated.
- You are behaving inappropriately (or threateningly, or in a way that's scary). You need to calm down right away or we won't be able to help you.
- You are using bad language. That's not allowed here.
- Your case manager isn't free now. Can you come back in a few hours when s/he might have an opening?
- You should know that we can't find you housing at the drop of a hat. I don't think we can find you a place to stay now that you've lost the group home.
- Since you've been drinking, you need to go to the ER to be medically cleared before we can see you.
- Before we talk to you, we need to let you know that we have to call your parole officer to let him know that you have probably violated your parole.

It is important to keep in mind that Carlos' life might very well be at stake here. If Carlos is upset enough, he can just storm out of the clinic without being seen. He is desperate and losing hope. He could easily do something that would hurt someone seriously, or get himself hurt or killed.

But ensuring that Carlos is highly likely to have a welcoming experience in our community program requires a deliberate and organized approach. The rest of this chapter will describe basic steps to build a welcoming environment and welcoming hopeful practice, as core features of any community behavioral health program.

Welcoming Systems and Welcoming Practice

During the past decade, increasing attention has been given to the use of organized strategies for building welcoming, hopeful, recovery-oriented programs and practices (Minkoff and Cline 2004, 2005). We have recognized that our systems and practices have been misdesigned, particularly for people with challenging co-occurring mental health, substance use, and health conditions who are often experienced as misfits. The goal of "transformation" is to design systems with limited resources to be organized at *every level* (system policy, program design, clinical practice, and staff competency) to welcome our customers as they are, with all their complexity and desperation, to respond to their needs, and to inspire their hopes and dreams.

Welcoming and hope as practice and philosophy are embedded in opportunities for improvement in systems, programs, and practices, many of which are discussed in more detail in other chapters.

- *Recovery-oriented systems* are built on a foundation that everyone is welcomed into empowered partnerships and inspired with the hope of recovery (Gagne et al. 2007).
- *Trauma-informed systems and services* recognize the importance of building welcoming partnerships for vulnerable individuals and families (Finkelstein and Markoff 2004; Elliott

et al. 2005; National Center for Trauma-Informed Care http://mentalhealth.samhsa.gov/ncitc/).

- *Restraint reduction and nonviolent deescalation* succeed most effectively in the context of creating a welcoming culture of partnership in an institution (Council of State Governments 2002).
- *The Network for Improvement of Addiction Treatment (NIATx)* has been successful in working with both addiction and mental health programs to use Continuous Quality Improvement to increase welcoming, access, and retention (NIATx outcomes 2011).
- *Homeless outreach and family wraparound programs* are built on a foundation of welcoming individuals and families who are difficult to engage (Gillig and McQuistion 2006; Friedman and Drews 2005).
- *Motivational interviewing* (Miller and Rollnick 2002) as a clinical practice begins with welcoming and engaging individuals who do not share our goals.
- *Shared decision-making* as a component of psychiatric practice (Torrey and Drake 2010) formalizes welcoming partnerships to promote adherence.

Comprehensive Continuous Integrated Systems of Care

For the past decade, the authors of this chapter have been working with state and county systems in over 30 states and four Canadian provinces, with all types of programs and clinical and non-clinical staff, to build welcoming, recovery-oriented, and integrated systems, programs, and services, designed to be about the needs, hopes, and goals of people and families with complex lives and co-occurring conditions of all kinds (Minkoff and Cline 2004, 2005). Comprehensive Continuous Integrated Systems of Care (CCISC) is an organized quality improvement process for system redesign in which every program and every person delivering care becomes welcoming, recovery- or resiliency-oriented (i.e., hopeful and strength-based), and capable of working with co-occurring behavioral health disorders.

In this chapter, we outline some of the strategies that have been used by systems and programs to not only make progress in welcoming the people served but also to inspire hope in and support the values of the people delivering service.

Strategies to Implement Welcoming, Hopeful Environments and Practices

As the preceding section suggests, welcoming is not just a matter of everyone being nicer. Welcoming involves a deliberate approach to both organizing welcoming as a "clinical practice" and to building a welcoming environment and organizational culture. If you are thinking that complex financially challenged behavioral health organizations cannot help everyone to be welcoming, you probably have never been to a hotel, a restaurant, or even a discount department store, because the starting place for welcoming involves basic customer service. There are well-designed organizational technologies for implementing customer service as a routine practice and for developing value-driven customer-oriented organizations. These strategies have been studied for years in the fields of management science and organizational development. What is striking is that in behavioral health we have not paid much attention to these strategies at all, even though we are in a "business" where whether or not people are welcomed, inspired, and engaged may be, as we said earlier—a matter of life and death.

Customer service strategies begin with looking at the whole organization from the perspective of the customer, beginning with the "easy" or "routine" customer, and then progressing to evaluating the experience and improving the service for customers who may have a harder time. A strategy used by NIATx, for example, is to experience the program or organization by performing a walk-through, in which management and staff, often accompanied by consumers or customers (as partners in the improvement process) "walk through" the experience of entering the program, and being "admitted" to service. For most behavioral health organizations, the walk-through is not only "eye-opening," it is "mind-opening." An administrator of a community

mental health center in Oklahoma "walked through" admission to his own facility as part of a CCISC project, and said to us afterwards: "I felt fine when I started, but within an hour and a half I wanted to hit somebody." He immediately began a project to redesign the whole admitting area, and the admitting process, to be more welcoming.

Creating a Welcoming Environment

Many organizations begin the process of improving welcoming by conducting a walk-through of their physical space. The goal of the walk-through is to experience the space through the eyes of a "customer" who may be scared, mistrustful, or angry, who may have multiple issues (e.g., substance abuse and health as well as mental health), who may have experienced past trauma at the hands of caregivers, and who may have cultural or linguistic barriers to care. Common improvement opportunities range from addressing interior decoration (plants, posters, and paint), to removing obviously unwelcoming signs ("Clients are prohibited from…"), to adding hopeful, culturally relevant signs and decorations that address recovery from multiple issues.

It is often surprising what clients perceive to be unwelcoming. In one of our CCISC projects, a drug and alcohol program in South Dakota was working on welcoming clients with co-occurring mental health conditions. The program change team decided to remove a huge rug in the admitting area that was embossed with "Say No to Drugs." Their idea was that this might be perceived as unwelcoming to clients who were on psychotropic medication. After they removed the rug, they were surprised how many clients came up to them and said "thank you." A typical comment was: "I'm so glad you got rid of that rug. Every time I walked in the door I was thinking that I'm someone who uses drugs and you were saying 'no' to me."

One of the most challenging issues in developing a welcoming environment has to do with the question of removing security items such as metal detectors, glass barriers in the waiting area or in front of the receptionist, and uniformed security guards. While there are clearly settings in which metal detectors and security personnel are expected (e.g., criminal justice settings), the value of such environmental barriers in improving safety in a usual community behavioral health setting is highly questionable. Research on violence reduction indicates that although staff may feel safer as a result of these devices, it is likely that any deterrent effect on the unlikely event of violent or unsafe behavior is counterbalanced by a general increase in adversarial or unwelcoming tone, which in fact increases the overall risk of violence from all clients (Council of State Governments 2002). However, as we shall discuss below, under no circumstances should the first step in improving welcoming be to remove those barriers over staff objections. The process of developing the partnership to create a major culture shift requires a well-considered organizational strategy, which is discussed in more detail later in this chapter.

Defining and Implementing Welcoming Practice

In any business, ensuring welcoming practice or good customer service requires great attention to detail. It requires that good customer service is defined and organizationally supported as a practice, with purposeful practice-support strategies and tools. Further, as addressed below, it involves a deliberate organizational implementation strategy that welcomes and empowers staff to produce the "product" of welcoming and empowering practice with customers (clients, families, etc.).

One way to think of welcoming practice is to divide welcoming into a number of different levels—basic, intermediate, and advanced or radical welcoming—and then consider how specific strategies and practices at each level are likely to challenge current behavior and create an improvement opportunity. This approach is designed to partner with staff, not to criticize them. Almost everyone working in behavioral health, including support staff, comes with a sincere desire to be helpful, and is usually distressed

to not only see unwelcoming behavior all around but also receive little guidance on how to be welcoming in challenging situations.

Basic welcoming: One way of modeling basic welcoming is to develop a script and then use the script to help develop a guideline for welcoming practice. The script should specifically push the envelope of common practice and push the envelope of which customers are proactively welcomed. The following script illustrates basic welcoming in a typical community behavioral health organization for individuals who might normally be experienced as "misfits" due to their co-occurring conditions.

> Hi, there! Welcome to our clinic. You seem to be someone who has many issues at the same time: mental health, substance use, medical, housing, etc. You know, you're a person we most enjoy serving here, because you're the kind of person who is often having the hardest time. We know it's not easy for you to come in asking us for help. Thank you for coming. You're in the right place. We're really glad you're here. We know our job is not to know how to fix you the moment we meet you. Our job is to get to know you, inspire you with hope, and help you to figure out how help you address all of your issues, over time, so you can have the happiest, most hopeful, and successful life you possibly can.

There is no "rocket science" in this speech. It takes less than a minute to say. The question to ask ourselves is: "As a community program, how well organized are we, by policy, procedure, and practice, so that everyone knows that when a person comes in the door, particularly someone who is challenging and feels like a misfit, that this is exactly what we are supposed to say, and from the heart?" "Basic welcoming" scripts can be developed, adapted, modified, and written down as guidance for everyone meeting clients at the front door, just like other customer service organizations do.

Intermediate welcoming: Intermediate welcoming addresses common practices that support an unwelcoming culture. For example, what if the organization develops a rule that says that no one can "trash talk" about clients or families in any way, even when they are not listening, including in chart documentation, just like no one may use racial slurs behind people's backs?

Negative and unwelcoming language is often routine practice in many community behavioral health organizations. We use terms such as "antisocial," "noncompliant," "manipulative," and "inappropriate" to express displeasure and frustration with clients who are seen as hard to engage and/or not doing what we want. We may use "borderline" or "Axis 2" as an epithet rather than as a diagnosis. We may refer to people with substance use disorders as "drunks," or write: "All he wants is to get high."

Language *is* important. How we talk and write about people affects the way we relate to them and can have a profound effect on our ability to engage and inspire. For example, if we say that someone is "noncompliant," it implies that our job is to use whatever power we have to make that person do what we think is good for them. On the other hand, if we say: "He or she is not finding what we are 'selling' to be of great value in their efforts to have a happy life," it tells us that our job is to better understand the person's vision and how to best attach anything we have to offer to his or her own goals.

Advanced (or radical) welcoming: Advanced welcoming, or radical welcoming, refers to those situations, as exemplified by the situation with Carlos described above, in which welcoming practices and strategies are needed for those individuals and families who initially appear to be hardest to welcome. What happens, for example, when someone comes to the door of one part of the service system displaying symptoms in the "other" domain? For example, a client comes to the door of the substance abuse service system displaying mental health symptoms that make it hard to "participate appropriately in care." Or a client comes to the mental health door—or either door for that matter—smelling of alcohol and unsteady on his feet. Or a mother drops her child off for a mental health appointment, and she smells of alcohol or marijuana. How do we make it our most important business, in that moment, to have that person feel really happy, that when they were in crisis, or challenged, or scared, they were

in the presence of people being paid to help them, rather than thinking our job is to tell them they have behaved badly and inappropriately, and to either kick them out as quickly as we can, or to threaten them with consequences? Strategies to support advanced welcoming practice in a community behavioral health organization require at least the same level of attention and organization as do strategies to support customer service for challenging customers in a hotel or in a retail store. This requires attention both to modeling or role playing radical welcoming practice (as illustrated with Carlos, earlier in this chapter) as well as attention to policies or rules that may inadvertently make welcoming more difficult, if not impossible (e.g., "No client will be seen who is under the influence of substances.")

Radical welcoming has long been a routine characteristic of services such as homeless outreach, or a best practice intervention such as "Pathways to Housing" (Tsemberis and Eisenberg 2000). In these situations, welcoming strategies involve entering the world of—and partnering with—someone who may be experiencing psychosis and/or using drugs, does not share our view of "the problem," and is unwilling to accept conventional services. A radical welcoming relationship begins with simple conversation, or an offer of a sandwich, and progresses to address other issues as trust builds. The radical welcoming of the persons *exactly as they are* is a critical feature of engagement.

Welcoming and Safety

In many community settings, being welcoming is viewed as in conflict with ensuring safety. Thus, welcoming becomes somewhat self-limited: "We will be welcoming *unless* you do something unsafe." This approach must be viewed through an entirely different lens.

As the research on restraint reduction and nonviolent deescalation has taught, welcoming *enhances* safety. (Council of State Governments 2002) In fact, the most important time to engage in welcoming practice is when a person is at highest risk. This does not mean that clinicians should put themselves in harm's way when a client is violent, or ignore the need for reporting abuse and neglect. What it means instead is the application of the following adage:

> The more risky the situation, and the more the client may need an involuntary intervention, the more attention should be paid to welcoming practice.

Thus, each clinic should have a procedure for identifying when involuntary interventions are required, and ensure that proactive effort is made to have the client experience a welcoming, positive human contact in the context of that intervention. If a client becomes violent to the point that the police or ambulance is called, it is important for the lead clinicians to look the client in the eye, and say something like the following:

> I know this is a terrible situation for you. We want you to know that you are a valuable person, and we care about you very much. We want you to be safe, so you don't hurt anyone or do something you might regret later. Most important, we want you to know that as soon as you are able to be more in control, we will be welcoming you back and working with you on how to make progress toward your goals.

Similarly, a clinic may have a welcoming statement for families that creates a context for the process of mandated reporting of abuse or neglect situations.

In every instance, methodical attention to welcoming policy, procedure, and practice becomes a priority for reducing risk and increasing safety in potentially volatile situations. Furthermore, as we now describe, welcoming is more than clinical practice development. It goes much deeper, and involves all aspects of organizational culture and the culture of the community itself.

Creating a Welcoming Organizational Culture

When community behavioral health organizations begin to improve welcoming, they often fall into a common organizational trap. The trap is assuming that the problem of "unwelcoming" belongs to someone else in the organization.

For example, clinical staff may say: "We need to train the receptionists to be welcoming" (as if the clinicians are already as welcoming as they could be). Similarly, program supervisors may assume that the case managers or clinicians "need to be trained" in welcoming.

A fundamental rule of organizational theory relates to customer service: If you want to produce a certain type of relational model with your customer, then you need to build a similar relational model internally in your organization. In other words, if we want to welcome our clients as partners, we have to welcome ourselves as partners in the entire process. This may be a radical culture shift for many behavioral health organizations. Building a welcoming organization is intertwined with organizational best practice strategies for developing vision-driven customer-oriented businesses strategies, such as continuous quality improvement or total quality management that many businesses have been using for decades, but have not been very well implemented in behavioral health.

Continuous quality improvement (discussed in detail in Chap. 30) is not just a project that is done to satisfy behavioral health systems regulators, and is certainly not the same as "quality assurance" (which is another term for "compliance monitoring"). It is a mechanism for engaging and empowering all levels of the organization in an empowered partnership to create more successful engagement, interventions and outcomes for customers at every level. The organization of this partnership is deliberate and structured, and involves purposefully identifying and empowering representatives from all levels of the organization to be engaged in the culture shift.

For example, in the NIATx process referenced above, the NIATx consultants help the organization develop an initial CQI project team to look at welcoming and access. This would be considered a small beginning step to help the organization learn how to use CQI techniques, with the hope that these CQI skills continue to expand and thrive within the organization in order to better serve the customers. The initial project team usually includes managers, supervisors, front-line staff, support staff (such as receptionists), and often consumers or families. Everyone has an important (and equal or democratic) perspective on the team. Receptionists in particular may be viewed as "welcoming experts" because they are constantly observing what works and doesn't work at the front door. For many organizations, just the process of welcoming front-line staff and consumers to be equal members of the change team represents a culture shift.

The team begins by engaging in a structured CQI process. The parameters of welcoming and access are identified. Markers of progress may be identified, such as "improvement in the rate of return" (that is, the percentage of people who come back after an initial appointment). The members of the team may conduct a walk-through where they role-play the experience of customers coming in the door. They may use techniques such as "secret shopper" to collect information about "baseline" welcoming over the phone. The team discusses the data it has gathered, and identifies multiple contributors (positive and negative) to welcoming and access. The team then learns how to use a basic CQI technique (e.g., *Plan-Do-Check-Act* or PDCA) to identify improvement opportunities and attempt to make progress. In the course of this process, members of the CQI team experience increased empowerment and excitement by virtue of having been welcomed to be part of the change process.

In our CCISC projects, we work with large systems and agencies to develop not just a single CQI project, but a comprehensive organizational culture shift. This process is described as engaging the organization in an ongoing CQI process where *every* program and *every* person providing care becomes welcoming, recovery- or resiliency-oriented (hopeful and strength-based), and co-occurring-competent (organized to work successfully with challenging people who have multiple needs). This framework takes longer to build, but has deeper results in creating a sustainable culture shift.

In this process, all the internal partners in the organization (all programs, all levels of staff, consumers/families) are welcomed to come to the table, and start to develop a representative CQI structure for the whole agency. Each program

does its own self-assessment or walk-through to determine its baseline, and then develops its own improvement plan, beginning with improvement in welcoming for people who are challenging or who may be otherwise experienced as "misfits." Each program identifies front-line people who are formally empowered as change agents. The change agents become a team that works in partnership with leadership, over time, to dramatically change the culture of the organization, both in relation to its customers and to itself. (Minkoff and Cline 2005)

The motto for many organizations becomes: "If we want to welcome the people we serve, we need to welcome ourselves as well." In this culture, every staff member is a valued partner in the learning community, who may have something to learn and also something to teach. Welcoming can become a common language through which all aspects of clinical and organizational behavior are vetted, and welcoming becomes owned as a positive value by all levels of staff. The best part of this, organizationally, is that quality and welcoming are not just the responsibility of the "quality department," but become a vision to which everyone contributes. Here is an example from one of our projects:

> The members of a case management team wished to create an initiative to improve its welcoming posture. A designated change agent on the team worked out a mechanism to help her teammates improve welcoming discussions in team meetings. She carried with her a small red feather. Whenever someone made an unwelcoming remark about client or staff, she would quietly and politely hand them the feather. The team experienced this as a welcoming intervention to help them start in process of being more aware of how they thought and talked about people who were having a hard time.

Creating Welcoming Communities

Community psychiatry is, after all, about communities. And welcoming as a framework extends well beyond the boundaries of the individual organization. All community behavioral health organizations operate in partnerships with other service providers in their communities (behavioral health providers, housing, criminal justice, health, child welfare, and so on).

Within these communities, welcoming occurs at two different levels. The first level is the application of welcoming practice to community partners. In this framework, community partners are identified as "organizational customers," just like clients and families. In crisis services, for example, success would be defined as helping a customer (a referring agency) solve a problem, rather than "diverting the client from the hospital" or "preventing an agency from dumping on us."

The second level is that the whole community system may make a collective commitment to improving welcoming, recovery-oriented, co-occurring-capable, trauma-informed care. This can be organized by a public behavioral health authority or it can be organized as a collaborative network of providers (Engelhardt et al. 2009: Konyndyk et al. 2009; Chichester et al. 2006). In either case, the effect of building a welcoming culture is dramatically enhanced when there is partnership among providers to adopt a common language and approach, in which each provider works on improving its own capacity to be welcoming, while all the providers join in a learning community to support each other and hold each other accountable for continuing progress.

Conclusion: Carlos, Revisited

The story of Carlos is fictional, but it is based on many real stories of people like Carlos who come to our doors in community behavioral health settings, essentially putting their lives in our hands. When resources are limited, and we are all under stress, welcoming can easily take a back seat if we do not organize our priorities. Carlos could become another statistic—hospitalization, homelessness, reincarceration, or death. But another outcome can occur, as a result of providing welcoming, hopeful intervention, from the heart, to people in great distress. We have experienced outcomes like this in our work with both individuals and systems.

> After his welcoming encounter with the clinician, Carlos calmed down considerably, got something

to eat, and was able to think through his options more calmly. He eventually took some extra medication, agreed to go to a crisis bed which welcomed him with alcohol still on board, and began to think about where he wanted to live in lieu of the group home. He role-played how to talk with his parole officer to ask for more help and for another chance to find a place to live. He agreed to check in with the clinic every day as part of getting help. He was still having a very hard time, and was guarded and paranoid at times, but he also started to trust the clinic staff to help him. About a month later, during one of his routine visits, he ran into the clinician he had seen during the initial crisis. Carlos looked so much better that the clinician barely recognized him. Carlos asked if he could talk to him for a minute. The clinician said, "Sure, what do you need?" Carlos said, "I don't really need anything; I just want to tell you something. I want to thank you. That day, when I came in here, I thought that no one really cared about me, and that you people would just treat me like a screwed-up ex-con and send me back to prison. When you sat down, looked me in the eye and told me you were proud of me, I was blown away. My life changed at that moment. I started to believe that there was some hope that someday I could actually feel human again."

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9 Collaborative Person-Centered Planning

Neal Adams and Diane Grieder

Beginning in 2002 with the release of the Institute of Medicine's Quality Chasm series (Institute of Medicine 2001; Institute of Medicine 2005), followed by The President's New Freedom Commission Report in 2003, the urgent need to transform the US mental health service delivery system became abundantly clear to all involved. The system was described as being "in shambles"(The President's New Freedom Commission for Mental Health 2002) and failing to meet the needs of adults, children and families seeking services.

The growing consensus was that the system needed to be far more recovery-oriented, person-centered, and integrated than it had been. While there are multiple definitions of recovery and recovery practice (Anthony 1993), the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) consensus definition captures the essence of what is meant by "mental health recovery" (Substance Abuse and Mental Health Services Administration 2006):

> Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

The definition also identified ten Fundamental Components of Recovery which included the importance of person-centeredness. The President's New Freedom Commission Report (President's New Freedom Commission on Mental Health 2003) also identified the need to transform America's mental health serviced delivery system to a more recovery-oriented approach and focused on the role of treatment planning as part of an overall strategy in the shift to person-centered systems and personalized care. Specifically, the Commission recommended *in a transformed mental health system, providers, in full partnership with consumers and families, should develop an individualized plan of care for managing the illness* (President's New Freedom Commission on Mental Health 2003).

However, in its 2008 monograph (Bazelon Center for Mental Health Law and Community Integration 2008), *In the Driver's Seat*, the Bazelon Center asserted:

> Even though state and local agencies often include consumers and other advocates in care planning, they often allow them to have only a marginal role and fail to provide important information that could enable them to participate fully and effectively.

Changing systems and practice has proved to be difficult for a number of reasons. However, a focus on the process and practice of person-centered

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planning can go a long way towards promoting recovery-oriented systems while supporting individuals and families in their own recovery journey.

Functions of the Treatment Plan

On a day-in and day-out basis, the person-centered plan (PCP) serves multiple purposes for providers as well as individuals (and their families) in recovery. Written plans can be the following:

- The social "contract" between the person served and the provider (serving as the road map, so everyone is going in the same direction)
- A means to support utilization management (both internal and external to the provider organization)
- A tool to decrease fragmentation and assure coordination between multiple providers
- Clear documentation of medical necessity (medical necessity refers to the appropriateness and efficiency of services that is often a focus of insurers and other payers and documented in the treatment plan and other components of the clinical record. While important to provider organization's financial functions, a full discussion of the topic lies outside the scope of this chapter.) Via the objectives and interventions on the plan
- A means for identifying everyone's role in the recovery process, including the person receiving services and/or their natural supports
- A way to ensure that the services being delivered are culturally responsive to the individual
- A clear articulation of the intended outcomes/discharge criteria
- A means for monitoring recovery progress and making course corrections

A pretty tall order for one document! Yet, done well, this written document can be a valuable clinical tool as well as an essential part of the record that satisfies multiple administrative and regulatory requirements. The creation, implementation, and ongoing modification of the PCP is *the essence of recovery work*—not, as regarded by many providers, merely a paperwork requirement keeping them from their "real" clinical responsibilities. Once the individual's recovery roadmap is drawn, everyone should know the direction and purpose of the journey and what's required to get under way. It can also serve as a means of anticipating bumps in the road or potential detours, and can help to prevent crises or anticipate helpful responses if and when they arise. Focusing on the plan and recovery progress/barriers in *every* clinical encounter can be an effective means of reducing the all-too-common "crisis orientation" many consumers (and providers) have to seeking services and managing life's inevitable challenges.

What Is a Person Centered Treatment Plan?

Person-centered treatment planning/plan (PCP) refers to a process as well as a document or record (Davidson et al. 2007). The process is one of collaboration, partnership and shared decision-making that actively engages and involves recipients of service and the provider team. The plan document or record is an organized and readily accessible description of the person's recovery hope and goals followed by an action plan as to how the individual and team together will work towards reducing barriers to wellness and recovery success. Both the creation and the documentation of a plan is a structured and logical approach to identifying goals, objectives, and actions, derived from well-established management planning models. PCP also includes participatory problem solving that builds on the individual's strengths to overcome the challenges in their life resulting from a mental health and/or substance abuse problem. PCP can also be viewed as a "social contract" between a person and a provider that details methods and "deliverables" for providers of mental health and addiction services and an individual seeking services to promote their recovery and receive support for their meaningful participation in the life of the community.

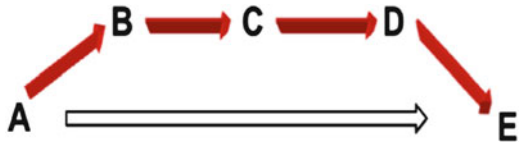

Fig. 9.1 Treatment plans are like road maps that help guide the recovery journey

The metaphor of recovery as a journey is quite apt. The PCP, from this perspective, is the road-map created to help guide that expedition. In Fig. 9.1 (Adams and Grieder 2005), *A* is the "starting point" and *E* the "end-point"; the transition to another level of care or attainment of the goal. The question to ask is: "why can't the person simply travel from *A* to E" as depicted by the open arrow. Because the person often faces barriers, obstacles and challenges in their journey, we identity mid-point "destinations"; *B, C,* and *D* are those mid-way objectives, the short-term intermediate stops or accomplishments along the way. The solid arrows represent the services and supports needed by the individual to guide them along the way.

In PCP, the individual receiving services is actively supported and involved in all phases of creating the plan—from preparation in arranging for and active participation in the team meeting where the details of a plan should be elaborated. Attention to the process should precede and shape the product, but all too often this is not the case. In fact, the CARF accreditation standards (CARF International 2011) state that the signature of the person-served on the plan documents and records is not "sufficient evidence" of meaningful participation in the plan's development. The all too common practice of the provider writing a plan and then simply asking the person-served to sign it is not person-centered planning—even if the goals, objectives, and services are strengths-based and recovery-oriented.

The three core elements of any plan are *goals, objectives, and interventions (or services).* Figure 9.2 identifies the additional steps and elements that help to assure that the PCP is indeed person-centered. Here is a brief description of these elements, with more detail to follow later in the chapter.

Goals

Proponents of psychiatric rehabilitation believe that effective services begin with an understanding of the person's goals (Anthony and Liberman 1986; Bachrach 1992; Mosher and Burti 1994). Goals are brief statements that capture the recovery hopes and dreams of the individual and help to assure that the person's own priority of needs are the focus of treatment and the ultimate destination of the recovery journey. Goals build upon the abilities/strengths, preferences and needs of the individual and are an alternative to current circumstances and identity the hoped-for destination to be arrived at through the services provided. Typically, they are long term, global and broadly stated, and describe the life changes that are desired as a result of services. Ideally, they are expressed in the person's own words, written in positive terms and consistent with culturally informed values of self-determination. In a recovery-oriented approach, goals are independent of a diagnosis and are not merely the amelioration of symptoms.

Objectives

Recovery often happens in small steps. In order for a plan to be an effective road-map, it should clearly identify the short-term intermediate steps that lead to the attainment of the larger goals. These markers along the way also offer an opportunity to celebrate and acknowledge progress. Objectives divide larger goals into manageable units of completion and provide time frames for assessing advancement towards the goal. From another perspective, objectives work to resolve the mental health and/or addiction barriers that challenge the individual's goal attainment. These barriers may include difficulties in functioning or self-care, burdensome symptoms, or other biopsychosocial

Fig. 9.2 Treatment plans are built in a logical sequence with each step building on the one that precedes

factors that might interfere with the person's effort to reach their goal.

Services/Interventions

These elements of a person-centered recovery plan specify the activities of multidisciplinary staff, family, peers, and other natural supports in the person's life/community and how they will work together to help support the individual in attaining their objectives and ultimately their goals. Services/interventions are specific to an objective and sensitive to the individual's stage of change/recovery—while at the same time respect their choices and preferences. This list of action steps may include both billable as well as non-billable services for the provider and as much as possible include a task for the individual, family, or other part of the person's natural support system.

The terms may be used with some variation—for example sometimes objectives are referred to as "short-term goals." Services are also sometimes referred to as action steps and refer to the specific activities of *all* members of the treatment team to help individuals overcome their challenges and barriers in an effort to attain their self-defined and goals and desired changes.

The development of the plan—and its written or electronic record—should be a stepwise process in which each step builds on the one that proceeds. Sometimes referred to as a logic model, the stacked pyramid (Adams and Grieder 2005) in Fig. 9.2 is a useful image to reinforce this notion: if one step is skipped or not done well, the foundation to support what follows as the plan is built is not adequate and the entire process is at risk of collapse.

Writing Plans

Defining and Gathering the Team

There is increasing recognition that (1) multidisciplinary teams are the most effective way to deliver a broad range of recovery oriented community mental health services, and (2) the team is responsible for both creating and assuring implementation of the PCP in partnership with the individual/family. The team should include representatives from several professions and clinical traditions, including but not limited to psychiatry, nursing, psychology, social work, and occupational therapy working collaboratively in a range of roles (Liberman et al. 2001; CARF International 2011). However, there are many who would argue

that the most critical—but all too often overlooked if not excluded—member of the team is the person served. Moving beyond person-centered to the notion of being person-*driven,* the client should have a major role to play in deciding when and where the team meeting occurs and who is in attendance, as well as the right to include important members of the person's family and social network. The team meeting to develop or revise the plan is a special event that should be given forethought and preparation.

Facilitating the Process

Each member of the team should have a unique but complimentary role. The team is the proverbial example of the whole being greater than the sum of its parts.

Leader

Ideally, the person directing the planning meeting should be the person receiving services (in the driver's seat!). Recognizing that not everyone is prepared to actually take the lead in their own treatment/plan/recovery, one important role of the team is to support and empower the person as much as possible. The individual ought to have a say in who attends the meeting with them and when and where it will occur. Having another team member, an advocate or a peer specialist to assist with supporting the individual in their participation and direction of the meeting is often very helpful.

Preparing the person prior to the formal planning meeting can help to promote participation. Describing the treatment planning process and explaining what a treatment plan is all about can help people think about their goals/life roles/hopes and dreams before the actual meeting takes place. Describing the person's role in the planning meeting, as well as using some preplanning techniques, is all part of preparing the individual to be an active participant. Other approaches might include Illness Management Recovery (IMR) (SAMHSA), an established Evidence-Based Practice which includes two modules on goal setting, or using WRAP Planning (Wellness Recovery Action Plans) (Copeland).

Consumer Role

Regardless of the approach, the person receiving services should come to the meeting prepared to discuss their goals/hopes/dreams, to ask for the support they may need, and to invite others to participate in the meeting who are part of their personal support system. Everyone involved should play a role in identifying the plan's interventions, and considering the person's strengths in overcoming the challenges/barriers in achieving their goals (Tondora et al. 2006).

Family Role

Family members and other members of the individual's support network should be encouraged to attend the meeting if they are a part of the person's life and the individual wants them to be present. Family members, too, should be educated about person-centered planning practices and understand their rights and responsibilities in advance of the meeting. Their contributions to the planning process can include providing the team with a strengths based view of the individual, corroborating data that the individual may not be able to express himself/herself, supporting the individual, and by being willing to assist with some tasks (interventions) on the plan to help further the person's attainment of their goals.

Frequency of Meeting/Review

A consumer recovery plan is built on the expectation of progress, movement and hope—regardless of the care setting or level of care. Regular review and modification of the plan helps to assure that it remains a viable, useful, meaningful, clinical tool relevant to the individual's ongoing recovery efforts and progress. For the most part, the time to review a plan and treatment progress should be set by the time frames detailed in each objective. Reviews of the plan/record should not be triggered only by "crisis" events.

Whether an objective describes a change to occur in several days or several months, that time frame should set the interval for plan review. Objectives should, for the most part, be built around measurable changes that can occur within no more than 90 days. In this way, at minimum, plans are reviewed quarterly (CARF International

2011; SAMHSA). When reviewed, consideration should be given to the ongoing relevance of all elements of the plan including, the goals, objectives, and interventions. When objectives are not met, alternative approaches or different objectives should be considered based on some shared understanding that helps to explain the lack of progress within expected time frames. When objectives are met, the task then is to identify the next objective to be addressed in pursuit of the overall recovery goal.

Assessment

An initial multidisciplinary assessment is the starting point of the planning process and should be conducted in a welcoming, helpful and engaging way. It can be the first step in building a successful recovery partnership. The approach should be flexible in order to be sensitive and responsive to each person's needs, anxiety, sense of safety, level of comfort, etc. The biopsychosocial assessment is both initial and ongoing—it serves as a means to gather data about the person at the beginning of their recovery journey, and for regularly updating information and a formal reassessment should be conducted at least on an annual basis.

A person-centered assessment should be holistic and place an emphasis on a person's strengths—not simply a focus on their problems or deficits. In the course of the assessment the provider should inquire about symptoms/functional impairments (e.g., occupational, social, school, safety, activities of daily living) and their impact on the person's life—but it is not the sole focus, nor is it the single driving force of the assessment. Strengths-based assessments are developed through an in-depth discussion with the individual as well as attempts to solicit collateral information from others in the person's life (or referral sources). Thoughtful consideration should be given to not only the individual's immediate strengths and resources, but also to those that are part of the person's abilities, talents and interests, competencies and accomplishments, previous strategies used to help the person and those available in the family, support network, service system, and the community at large.

The Importance of Understanding

General Considerations

Collecting data is necessary, but that alone is not a sufficient step in building a PCP. Instead, a formulation or understanding should help the team move from "what" to "why," and reflect "critical clinical thinking" and be recorded in the chart. Often referred to as a narrative diagnostic, interpretative, or integrative summary, the formulation is a bridge between the data gathered for assessment and the written plan. This summary should include what is known about the person's strengths and culture, challenges and symptoms, and consider the individual's readiness or stage of change (Prochaska 1992). Interrelationships and themes should also be considered—especially for individuals who have co-occurring disorders.

The formulation of assessment data is more than a retelling of the facts. Instead, the narrative summary helps set the stage for prioritizing needs and goals as well as suggesting solutions to the barriers and challenges that have led the individual to seek help. A well-written formulation helps to clarify and the individual's desire and motivation for change. It also demonstrates that the practitioner has heard the consumer, woven the pieces of the story together into a coherent summary, and is now ready to work with the person on a plan for the recovery journey. Plans developed without a meaningful summary serving as the bridge between the data collection and the plan, often "fall apart" and make little sense. Yet, this necessary and important step is all too often overlooked in community mental health practice.

Developing this kind of understanding typically requires some degree of clinical skill and experience but should be shared with the person (and the family, if so desired by the individual) as a way of building a healing partnership based on

transparency, respect and compassion. This is the clinician's opportunity to state their clinical impression of what all the data means. Sometimes the initial understanding needs to be modified to include the individual's own understanding and perspective.

The 10 Ps are a brief outline that can be useful in capturing the relevant information on a formulation (Adams and Grieder 2005):

1. *Pertinent history*: a brief summary
2. *Predisposing factors*: issues such as a history of trauma, or a biological disorder
3. *Precipitating factors*: the key question is "Why now?"
4. *Perpetuating* factors: what holds this problem in place, what keeps it alive? It is important to look at treatment plans that have remained the same for years and years—this contributes to a lack of success
5. *Present condition*: what are the current circumstances that led the individual to seek help
6. *Previous treatment and response*: what has helped in the past?
7. *Prioritization*: what's important for the consumer at this time? Without this factored in, we often miss the boat
8. *Preferences:* what does the consumer feel would be most helpful? What is the consumer's input?
9. *Prognosis*: what do we think would best contribute to the individual's recovery?
10. *Possibilities*: what do we (and/or the consumer) see as possibilities for his/her future?

This list is not meant to suggest that all the "P's" must be addressed in the narrative, but rather to offer a guide to help clinician's organize and write the summary

Cultural Considerations

Yet another approach to formulation can be found in the Cultural Formulation included in Appendix I of the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV (American Psychiatric Association). Participation in PCP will be influenced by an individual's cultural worldview and understanding the role of culture and ethnicity is essential for the person(s) to be understood, to engage in a working relationship, to acknowledge cultural strengths, wellness, resilience and recovery, for cultural humility and responsiveness. A cultural formulation should consider the following four factors:

- *Cultural identity:* cultural reference groups; language(s); cultural factors in development; involvement with culture of origin.
- *Cultural explanations of illness:* idioms of distress; meaning of symptoms in relation to cultural norms; perceived causes; help-seeking behavior.
- *Cultural factors related to psychosocial environment and levels of functioning:* social stressors; social supports; level of functioning/disability.
- *Cultural elements of the clinician-patient relationship:* clinician's ethno-cultural background; language; knowledge of patient's culture.

Stages of Change and Recovery

Increasingly there is recognition of the importance of considering the individual's "stage of change" in order to be most effective in promoting and supporting their recovery journey. In the early 1990s Prochaska and DiClemente (Prochaska 1992) promoted their trans-theoretical model of change with stages that help to provide a nonlinear view of the process of change. Adapted for use in community mental health practice, five stages can be identified. A person in the

- *Precontemplation stage* may not be aware they have an illness and are uncertain why they are even in the mental health system.
- *Contemplation stage* typically feels two ways about it: "yes, it might be good for me, but no, I don't really want to be here or change anything."
- *Persuasion/Preparation stage* makes the beginning steps to make changes and accept their illness and need for services.

- *Action stage*, establishes a goal and wants to move towards it.
- *Maintenance stage* is concerned with issues such as relapse prevention and sustained success.

Another approach to thinking about stages of change was developed at Boston University's Center for Psychiatric Rehabilitation Consulting (2001). Instead of "precontemplative," the person is seen as overwhelmed by their diagnosis of mental illness. As opposed to being "contemplative," the individual sees life as limiting, without much potential for recovery and therefore is not yet ready to commit to making changes in his/her life. Then to parallel the "preparation" stage, the person begins to see that there is more to life than the impact of a disabling illness and is willing to explore possibilities. Finally, the person may be in the "active" stage, taking action and responsibility.

The purpose of assessing/thinking about the various stages of change, no matter what they are called, is not to "label" people. Identifying stages of change helps us to have a richer understanding of the person and to be better able to help with developing a person-centered recovery/treatment plan—especially when it comes to the objectives and interventions. It's also important to remember that stages of change are not fixed or static but rather dynamic and change over time and can be influenced by the sense of hope that comes with any recovery progress. In some instances, motivational interventions can help people who seem stuck in the precontemplative and contemplative stages (DiClemente 2008).

It's not unusual in the mental health field to find plans written as if everyone is in the action stage; ready, willing and able to meet dynamic objectives, benefit from services and be an active participant in their own treatment. However, in many instances, people seeking services and supports have a limited sense of their own recovery potential and are more likely to be in the precontemplative/contemplative stages—especially those who are "externally motivated" for services (legal mandates). Developing a person-centered plan requires sensitivity and awareness to the stage of change. For example, a well-intended plan that includes lots of groups and rehabilitative activities 5 days a week and reliance on natural community supports (that might be appropriate for active treatment) is of little value and relevance for an individual who feels overwhelmed by their illness. Not considering the person's stage of change can set the stage for frustration and failure for the individual as well as for the provider. It's not unusual to hear someone who does not engage in all the services be described as "noncompliant" or "in denial." A more person-centered approach is to appreciate that the person was not yet ready for those services and that the plan did not recognize or coincide with their stage of change

The focus of treatment, i.e., the objectives and interventions, vary for each individual at each stage of readiness for change. For those who are in the precontemplative stage, providers should offer outreach, relationship building, practical help and crisis intervention as needed. People in the contemplative/preparation stage may benefit from interventions that include building awareness, psychoeducation, and goal setting. Individuals in the active stage are typically ready to benefit from counseling, skills training and self-help groups, while those in maintenance/relapse prevention stage are more open to skills training, relapse prevention planning, and expansion of their recovery horizons.

Goals, Barriers, Challenges, and Needs

Goals have been discussed in some detail earlier in this chapter, but it is worth restating that the provider's role is to help people, based on our understanding of them, their strengths and dreams, identify and articulate their recovery goals. The goal belongs to the individual; this is perhaps one of the defining characteristics of person-centered care. The issue is not about their being realistic or attainable as much as it is about acknowledging the individual's vision of satisfaction and well-being. Not unlike stages of change, goals may change over time as people truly engage in recovery.

Barriers, needs, and challenges are those factors in a person's life that get in the way of attaining their goals—especially those that arise related to their mental health problems. These factors are hopefully identified in the comprehensive assessment process and explained in the narrative summary or formulation. Understanding how something is a barrier is often key to coming up with effective solutions in the plan. In identifying barriers, it is important to be specific about the barrier and how it prevents the person from reaching their goals. Barriers can include things like lack of skills, lack of transportation, a difficult symptom or limited access to services, functional impairments, fear of failure, behavioral problems, abuse, drug/alcohol use, or anything else that can stop a person from moving forward in their life.

Establishing Priorities

Most people can only manage one or two personal development goals at a time. Yet, oftentimes, plans are often created that include an unrealistic multitude of goals. Trying to decide what is most important and what should be the focus of treatment can often be difficult. From the provider point of view, assuring the ultimate health and safety of the individual typically takes precedence over the preferences of the person served. Even in these situations where risk may be apparent, the most successful approach is to find a negotiated mutual agreement. Patricia Deegan (http://www.intentionalcare.org) has worked to articulate a core set of principles that can increase a provider's sensitivity to issues of control and partnership and help to establish common ground.

Establishing Objectives

Individuals seek help and receive services because they have reached an impasse in their life and find themselves unable to solve their own problems and move towards their goals. The team assists in helping to establish realistic, responsive objectives that help individuals to overcome the barriers and challenges they face by describing manageable steps they can take towards achieving their goals. Setting objectives involves supporting/pursuing changes that will help the individual to remove or overcome their barriers.

Objectives should build on the person's strengths and identify accomplishments in terms of changes in behavior or functioning and learning new skills and abilities, including the ability to access new supports and accommodations. Objectives can be thought of as interim goals that break down longer-term aspirations into meaningful and positive short-term changes that have a high probability of success. A smaller number of objectives are recommended to create focus and reduce the chances of feeling overwhelmed. This can be difficult for providers and consumers alike, as each may be tempted to tackle every single thing on the consumer's list. But, success breeds success, so as much as possible, the provider assists in maintaining a clear focus.

Target dates for accomplishment are a key element of each objective. This offers a sense of forward momentum and an assumption of success. Sometimes objectives are so big that they seem like goals—other times they are so small they make the changes seem trivial. Part of being person centered is making sure that the scope and time-frames for each objective are sensitive to the strengths and abilities as well as challenges of each person. Objectives should be written in language understandable to the individual and should also be measurable—there should be a simple agreed upon way to know if an objective is achieved. Measurement can occur by any number of means including self-report, another person's observations, by rating oneself on a scale of 1–5 (e.g., improved symptoms), by pre- and posttest evaluation, etc.

The SMART acronym is a useful tool to help develop objectives that work: they should be straightforward (or simple), measurable, achievable, realistic, and time limited. Participation or attendance in services is not an objective—although this is a common source of confusion and error made in developing plans. Objectives are the changes that occur for the individual—services describe the activities that help bring about desired changes.

Deciding on Interventions

Interventions are sometimes referred to as strategies, services, or supports. Regardless of the specific term they describe the activities that all members of the treatment team, including the person served, commit to doing in an effort to support attainment of a particular objective. Since the recovery plan is a formal document that effectively becomes a work agreement or "social contract" between the consumer and provider, interventions have a specified format that clearly spells out the roles and responsibilities of each party. This format includes a description of the intended purpose or impact for each activity and creates a clear link back to the objective and narrative summary. It also provides a forward link to progress notes written for each encounter. Interventions are tied to the stage of change as described above, as well.

Interventions must always respect the individual's values and preferences—not all potentially available services will be acceptable to everyone. Past treatment history—both successes and failures—and cultural factors may play an important role in shaping those preferences. At the same time, it is important that providers bring forward and explain evidence-based practices and include them in the choices and options available to the person served. For example, those individual's hoping to return to work as part of their recovery should be made aware of what is known about the success of Supported Employment and the range of activities that are embedded in that established efficacious practice.

In a recovery-oriented approach, interventions should ideally include both billable clinical services as well as the creative use of natural supports. Illness self-management strategies and daily wellness approaches such as wellness recovery action plans (WRAP) are respected as highly effective, person-directed recovery tools and should be explored as potential interventions. Other natural supports and/or self directed activities might include exercise, nutrition, self-help, peer support, increased involvement in community activities, volunteering, etc.

Providing Services and Documentation

Progress notes serve multiple functions. They provide a written record of treatment activities and are an important part of the documentation required in billing for the service being provided. In order to meet payer and regulatory requirements, documentation for all billable services should link back to the assessment, narrative summary and plan. In writing progress notes, providers should reference the specific goals and objectives that are detailed in the plan: what is the objective being addressed by each service and what was the immediate impact of that intervention. Each progress note is in essence a miniassessment that evaluates the individual's participation and the provider's activities, the effectiveness of services, and what next steps are indicated for continued support of the individual's recovery.

Evaluating Progress/Update and Review

The recovery plan is a living document—if it stays in a file drawer until the next time it is due for revision, it becomes simply paperwork exercise and loses the impact and value it can have. The plan should guide the daily work or individuals and providers in their recovery partnership—it should be utilized and reviewed for relevance regularly, not just during mandatory/regulatory review and revision time frames. The need to reevaluate the plan can be based on the emergence of new information or enhanced understanding, unexpected developments or new situations arising, as well as changing elements of the plan as needed, and driven by the successful attainment of goals and objectives.

The review of the plan ideally occurs with the entire team, and interim changes, should they occur, clearly need to be considered during scheduled team meetings. Reviewing the plan and writing progress notes are all about being accountable and meeting the "deliverables," as spelled out in the plan. Has the person attained the objectives or met

their goal? If not, what further is needed to support them in their recovery efforts. The deliverables are the target dates for objectives and interventions and the services (interventions) being offered.

Summary

A person-centered approach to planning is a way to "make recovery real" and translate the principles of recovery into every day practice. Endorsing the values is not sufficient—they must be reflected in how services are organized and delivered. The creation of a person-centered plan in full partnership with the person served is a critical part honoring each individual's unique strengths, needs, hopes and dreams to live a fulfilling and meaningful life despite the challenges of a mental health problem.

The following pages provide two examples of narrative summaries and treatment plans for the same individual, "Mr. Vernon Blake." In Example I, the summary and plan are developed from a "traditional" or deficit-oriented approach. In an effort to make clear what has been described in the preceding pages, Example II is written from a strengths-based and recovery oriented approach. The differences and advantages to the person-centered example narrative and plan will be obvious.

Example I

Vernon Blake's Traditional Narrative and Plan

Patient is a 33-year-old African American Male who has been living in a shared-apartment program with residential and clinical supports for 12 months following years of intermittent homelessness and repeated psychiatric hospitalizations. Currently, patient has frequent visits from various staff who monitor his status, manage his money, and deliver his medications twice daily. As he has become more dissatisfied with his progress, he started missing visits from his Medication Monitor as well as the Benefits Specialist who helps manage his money. Patient is being treated for a diagnosis of schizophrenia. He experiences paranoia, depressive mood disturbance, and cognitive disorganization.

Written records and the report of family members (mother and cousin) suggest that patient was exhibiting signs of severe depression, social isolation, and strange behaviors in his late teens and early 20s. However, patient did not have his first full-blown psychotic break and hospitalization until the age of 24 after the sudden death of his infant son from an undiagnosed heart defect. The child—the product of a brief relationship in his early 20s—regularly visited patient at the apartment he shared with his mother until the child died suddenly while in his care at the age of 10 months. Patient was unable to wake the child from a nap, and his attempts to resuscitate the baby were unsuccessful. Autopsy indicated that his son passed from an undiagnosed heart defect, but patient became convinced that someone in the building had killed the child through poisoning and that he had failed to protect the child. He was hospitalized after he threatened and punched a neighbor whom he had accused of being involved in the death. Patient's mother and cousin report that he never fully recovered from this loss, and that the event touched off nearly a decade of psychiatric instability, repeated hospitalizations, and periods of homelessness.

After years of inconsistent use of medications, recently, patient has responded well to a combination of fluoxetine and risperidone to treat symptoms of depression and psychosis. While he has consistently been taking these medications for the past 10 months, he does not talk openly about his meds or his illness other than to say that he "gets nervous when people mess with" him and the meds keep him "calm" when he is not doing good. Patient does not report any suicidal or homicidal ideation and is not currently considered to be a risk to himself or others.

Patient had limited experience living on his own or maintaining a household until his recent experience in the shared-apartment program. Residential Counselors report that he gets very disorganized and does not follow a routine to take care of his responsibilities—including paying his bills and household chores. He tends to spend a lot of time in his bedroom, watching TV and fixing small electronics that he finds in

neighborhood dumpsters and repairs to make money. When he has lived in apartments in the past, he has become suspicious of neighbors and did not participate in any community activities as a result of these feelings.

Patient was unable to finish high school due to his mental health issues, but during a period of relative mental health stability 3 years ago, he was able to complete his GED with the help of a tutor at a local psychosocial rehabilitation program. Patient is currently receiving SSI benefits. His money is managed by staff at his shared-apartment residential program, and he is given a minimal daily allowance. He would like greater control of his money but admits he has little experience with managing his finances or paying the types of bills that will be associated with a move to an apartment of his own.

Traditional Treatment Plan for Vernon Blake

Treatment Goal

Affordable Housing

Objectives

1. Patient will express motivation to enroll in the supported housing program.
2. Patient will sign a behavioral contract to comply with supported housing program rule and procedures.
3. Patient will attend all housing appointments and complete paperwork.

Intervention

1. M. Lofthouse, case manager, to complete housing referral and facilitate re-enrollment in Housing Program.

Example II

Vernon Blake's Person-Centered Narrative and Plan

Vernon values his independence and speaks up for what is important to him. Over the past decade, he has demonstrated remarkable resilience surviving highly distressing psychiatric symptoms, the traumatic loss of a child, and extended periods of homelessness. Through all these experiences, he maintained a positive connection to a cousin as well as a local thrift-shop owner. Vernon also describes his mother as being an important source of support, though their relationship has been strained at times as he has struggled with his mental health issues and impairments associated with a diagnosis of paranoid schizophrenia.

In the past 12 months, Vernon has successfully been living in a shared apartment program with clinical and residential services. This represents his single longest period of time living in the community as an adult, and it is a significant change from what has been a long history of distrust and disconnection from formal mental health services. While he is proud of this achievement, he wants to move to a "scattered site" apartment of his own where he will have more privacy and control over his life, finances, and medications.

The team would like to support this decision but staff are concerned regarding Vernon's ability to manage his medications, his budget/finances, and his relationships with new neighbors. He has continued to experience persistent symptoms of both paranoia and cognitive dysfunction while living in the shared-apartment program over the past year, and, in their opinion, Vernon has not yet developed the skills and coping strategies he will need in order to manage these symptoms and succeed in a lower level of care. He tends to minimize the impairments he experiences, and he sees the world as a dangerous place—a perception which is further complicated by unresolved issues of grief and loss over the death of his son, e.g., "There is nothing wrong with me. People just have it in for me." At the same time, he has made significant progress in the past year in beginning to discuss his "nerves" and how he feels uncomfortable around other people or sometimes get confused and neglects things around the house. He has been taking medications consistently and generally making use of services offered to him. He vacillates between the contemplation and action stage of change but is willing to participate in

programming which will move him closer to his goal of living and working in the community as independently as possible. Vernon has many strengths to draw upon as he works toward this goal including: a strong work ethic, enduring natural support relationships, an improved relationship with his treatment team, an ability to learn and complete tasks (e.g., persisting to achieve his GED), and a desire to be more independent and to reconnect with preferred community activities.

Person-Centered Recovery Plan for Vernon Blake

Goal

"I want my own apartment to live in."

Strengths

He recognizes need for skill development; basic math skills are intact; family is willing to assist; increasing recognition that the meds help with "nerves" and feeling uncomfortable around other people; consistent use of medications in past 10 months when delivered by staff nurse and prompted; desire to learn and be more independent with med self-administration.

Barriers/Assessed Needs

Vernon has limited experience budgeting and paying his own bills as he has had staff manage all of his affairs during his stay at the shared-apartment program, and prior to this, he resided with his mother or was homeless for long periods of time. Symptoms of depression and cognitive disorganization have also led Vernon to neglect bills in the past and failure to pay his rent has led to eviction proceedings. Baseline budgeting skill level has led to daily allocations of funds which Vernon objects to.

Cognitive symptoms lead to forgetfulness in taking meds; can become disorganized and have difficulty accurately identifying pills and correct dosages; concerns regarding side effect, e.g., fatigue, may contribute to inconsistent use of medications; baseline med administration skills has led to twice daily visits from the visiting nurse which he would like to reduce.

Objective 1

1. Vernon will successfully budget a weekly (rather than daily) personal allowance over the next 6 months as evidenced by report of Residential Counselor.

Interventions and Action Steps

1. Mary Tomason, Rehab Therapist, to provide Money Management skill-building group 1× per week for next 6 months in order to build personal budgeting skills and to provide support as Vernon assumes greater control of his money.
2. Anthony Sells, M.D., to provide medication evaluation and monitoring 2× per month for the next 6 months for purpose of decreasing symptoms and maximizing functioning, including his ability to manage his own funds and attend to bills.
3. Sam Narrato, Peer Support Specialist, will meet with Vernon 1× weekly for the next 2 months to assist him in completing a Wellness Recovery Action Plan in order to identify simple, safe, effective strategies for keeping himself well as he assumes greater control of his money.
4. Ronnie P., Vernon's cousin, has agreed to help him outline and bring in records of his expenses in order to assist Vernon and Benefits Coordinator in creating a modified budget.

Objective 2

Within 90 days, Vernon will demonstrate ability to accurately self-administer his morning dose of psychiatric medication as evidenced by nursing services report.

Interventions and Action Steps

1. Rashida Waters, RN, to provide Medication Education, 2× per month for the next 6 months in order to assist Vernon in effective use of medications to decrease symptoms and to address evaluate/address any of his concerns regarding side effects, e.g., fatigue.
2. Sam Narrato, Peer Support Specialist, to provide Meds & Me group, 1× per week for 3 months in order to assist Vernon in becoming more informed about his meds and more comfortable talking with his

doctor/nurse about any concerns/questions he may have.

3. Connie Clayton, Clinic Therapist, to provide Individual Therapy, 2× per month for the next 3 months in order to assist Vernon and the visiting nurse with identifying barriers and developing compensatory strategies for med self-administration.
4. Mr. Jansen, his friend who owns the thrift-shop has agreed to help Vernon purchase a pill box within 1 week so that he can use this to better organize his daily meds and dosages with the visiting nurse.
5. Ronnie P., Vernon's Cousin, will text him every morning from work to remind him to take his meds.

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10 Peer Service Providers as Colleagues

Paolo del Vecchio

Introduction

The dawn of the twenty-first century has brought a new professional workforce to mental health—individuals in recovery from mental health problems as service providers. Known by various titles (e.g., peer specialists, consumer providers, recovery coaches, etc.), these individuals use their lived experiences to assist others to cope with mental illnesses and to navigate our highly complex behavioral health, primary care, and associated social service systems.

This chapter will review the development of this new profession, the evidence for peer-provided services, and the roles and settings where such services are provided. A major focus will be on how community psychiatrists can work with peer providers to promote recovery from mental illnesses.

Peers as service providers grew out of the mental health consumer self-help movement. This movement began in the United States in the late 1960s and early 1970s when small groups of ex-patients or consumers of mental health services began to meet in major eastern and western coast cities. They formed groups for three primary purposes: (1) mutual support—providing reciprocal emotional support and encouragement based on common experiences; (2) information and social learning—educating members on coping strategies and on services available in their local and state communities; and (3) advocacy—participating in both individual case advocacy (to assist members with service access and rights protection) as well as systems advocacy. The latter was useful to foster needed reforms including the need to address the stigma and discrimination experienced by people with mental illnesses (Van Tosh and del Vecchio 2001). Over time, the number of these groups expanded including the development of state and national consumer organizations as well as publications, annual conferences, and other efforts. Starting in the late 1970s and into the 1980s, the Federal government, through the National Institute for Mental Health (NIMH)'s Community Support Program (CSP), began to endorse the benefits of these activities and to fund consumer-led organizations

One of the significant accomplishments of this movement has been the development of consumer-operated service programs. These are services that are primarily planned, developed, and evaluated by mental health service consumers—although some models use traditional mental health professionals for certain parts of their services. In essence, mental health consumers expanded their role from simply passive recipients of care to actually providing care themselves. Fountain House is a well-known psychiatric

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rehabilitation program in New York City. It was initially developed as a consumer-operated service. Consumer advocate and author Judi Chamberlin's 1978 book entitled "On Our Own: patient controlled alternatives to the mental health system" (Chamberlin 1978) was a landmark work, documenting the development of peer-provided service programs. Consumer-provided services are now a well-established model that includes drop-in centers, housing programs, homeless services, crisis response, benefits acquisition, public education, employment, research and much more.

Again, the Federal government played a key role in promoting such approaches including funding national technical assistance centers to help grow such models and research to examine and document their value (Clay 2005).

One of the outgrowths of the development of consumer-operated services has been the use of peers as providers in traditional mental health treatment settings. This paradigm shift has seen the role of peer-delivered services moving from its position as solely an alternative to the mental health system to one in which it is now working in partnership with treatment professionals.

An early model for such efforts was the Colorado Consumer Case Management Aid Program begun in 1986. It consisted of training and employing people with serious mental illnesses to provide case management services to other consumers in the state's public mental health system. In 1991, it was a finalist for the prestigious Harvard Kennedy School's Innovations in American Government Award (Government Innovators Network, Harvard Kennedy School 1991).

Since that time, we have seen the growth of such approaches and now virtually all states have developed or are implementing peer specialist programs, often with extensive training and certification initiatives (Daniels et al. 2009). In 2004, the National Association of Peer Specialists, a national trade organization for this specialty profession, was formed with representatives from all of the states (National Association of Peer Specialists 2010).

The growth in peer specialist services is being driven by several factors. First, as highlighted in the next section, there is growing recognition of the efficacy of these approaches in promoting recovery from mental illnesses. Peer-delivered services and approaches have been cited by the U.S. Surgeon General's Report (US Department of Health and Human Services 1999), the President's New Freedom Commission on Mental Health (President's New Freedom Commission on Mental Health 2003), and the Institute of Medicine (Institute of Medicine 2006). Financing and cost are other key drivers in promoting the use of peer specialists. The use of peer providers can be an efficient and cost-effective way of providing care. An August 2007 the Center for Medicare and Medicaid Services' (CMS) letter to State Medicaid Directors was another milestone in the development of peer-provided services (Smith 2007). This correspondence provided guidance to states on how they can bill Medicaid for peer-delivered services while noting that "CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment."

Evidence for Peer-Provided Services

There is a body of evidence from multiple studies that document the benefits and efficacy of peer-operated services including the following outcomes: reduced symptoms, improved well-being, reduced hospitalizations, enhanced empowerment, expanded social supports, increased self-efficacy, and greater consumer knowledge (Van Tosh and del Vecchio 2001; Campbell 2005).

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) completed the largest multisite controlled study of consumer-operated services. The 5-year, $20 million effort examined such programs as an adjunct to traditional services and determined that consumer-operated services enhanced the well-being of recipients as compared to services as usual (Teague et al. 2005). Based on these findings, SAMHSA is in development of an evidence-based practice toolkit to increase the adoption of such models.

The use of peer specialists in traditional service settings also has been shown to have positive results. An NIMH CSP-funded research demonstration project in Philadelphia investigated the effectiveness of consumers as intensive case managers (Solomon 1992). It found that consumers were as effective as nonconsumers in providing case management services. Other services have replicated these findings and also shown positive outcomes including shortened lengths of hospital stays, decreased frequency of admissions, reduced need and use of mental health services overtime, and a subsequent reduction in overall treatment costs (Daniels et al. 2009; Solomon 2004).

Roles and Settings for Peer Providers

Peer specialists provide the following fundamental roles and services to recipients: (1) offering social support; (2) sharing experiential knowledge; (3) and helping to broker the needs of consumers. These are identical to the foundations of the consumer movement. Further, they assist consumers by increasing the outreach and engagement of individuals served, acting as powerful sources of motivation, and serving as mentors and role models (Solomon 2004; Chinman et al. 2008). They also help recipients navigate often-fragmented services, assist with transportation and other life skills development, act as liaisons and mediators between staff and recipients, augment overburdened clinical staff, and help to challenge the often unacknowledged stigma and discrimination faced by people with mental illnesses (Chinman et al. 2008). Finally, they assist treatment providers by encouraging the adoption of recovery-based principles and approaches such as holistic and integrated services, person-centered planning, and trauma-informed care (Substance Abuse and Mental Health Services Administration 2006).

An added benefit of working as peer specialists is that these individuals also help themselves by helping others. The "helper-therapy principle"—something traditional providers experience as well—results in the helper experiencing a heightened sense of self-mastery, competency, and self-esteem (Solomon 2004).

Peer specialists are found in an increasingly large array of service settings including outpatient clinics, inpatient settings, assertive community treatment teams, residential settings, psychosocial programs, vocational initiatives, and others. They are working with a variety of populations including individuals involved in criminal justice settings, persons who experience homelessness, trauma survivors, and individuals with co-occurring substance use problems. Key areas with which peer specialists can assist are helping recipients with co-occurring physical health conditions: (1) access primary care, (2) practice self-management for chronic illnesses, and (3) smoking cessation (Daniels et al. 2009; National Association of Peer Specialists 2010; University of California, San Francisco 2010).

Working with Peer Providers

Peer specialists are a valuable asset and partner for the community psychiatrist. The following section reviews how peer specialists assist clinicians in promoting recovery, the administrative issues in establishing and sustaining such efforts, and the challenges and suggested solutions with such approaches.

Peer Specialists in Clinical Treatment

Peers play key roles in conducting outreach and engaging consumers into clinical services. Through sharing common experiences, peers can establish rapport and trust more quickly than traditional mental health treatment providers. These findings are particularly supported for those who are considered "most alienated from the health-care service system" (Sells et al. 2006). Having "been there," peers are also more often able to conduct outreach in naturalistic settings—on the streets, in home, and community-based settings (Solomon 2004). On a highly practical level, peer specialists also help consumers to attend their treatment appointments by giving them reminders

or assisting with transportation (Chinman et al. 2008). Further, as noted above, peer specialists provide an important role model that motivates consumers to engage in recovery and mental health services. Peer specialists bring the essential message of hope which acts as a catalyst for people to begin their journeys of recovery (Substance Abuse and Mental Health Services Administration 2006).

Both the Institute of Medicine (Institute of Medicine 2006) and the President's New Freedom Commission on Mental Health (President's New Freedom Commission on Mental Health 2003) cite the imperative for consumers to be actively involved in their own treatment as a means to improve systems outcomes. Peer specialists play an important role in teaching mental health literacy to those they serve. This includes providing information on how to access crucial supportive services and benefits—including Medicaid, Social Security, housing, employment, and others. Further, research has revealed that the information provided by peer specialists is viewed as more credible than those provided by mental health treatment providers (Woodhouse and Vincent 2006).

Decision Support

Through shared decision-making, peer specialists also assist consumers to work with their clinicians to make informed treatment decisions. SAMHSA has recently developed decision aids to assist consumers to partner with providers to make decisions about anti-psychotic medications and other issues (Mental Health Services Administration 2010). Peer specialists assist consumers in weighing the benefits and costs of treatment options prior to having a treatment encounter with a clinician. Such approaches can improve clinician efficiency, increase consumer engagement in services, and enhance consumer satisfaction with services. Additionally, peer specialists assist consumers in identifying personal goals and objectives that can help clinicians and consumers in developing person-centered treatment or recovery plans (Chinman et al. 2006).

Information Access

As also noted above, peer specialists act as a communication liaison between consumers and clinicians to translate clinical terminology as well as relay consumer concerns. Regarding the former, jargon and terminology used by clinical staff may be alien to and even alienate service recipients. Peer specialists use lay language to increase consumer understanding. Regarding the latter, for a number of reasons, consumers may be reticent to actively voice their dissatisfaction with service provision. Peer specialists help provide that voice to make sure that consumer needs and preferences are met. As such, it is important for peer specialists to be active and equal members of the treatment team (Gates and Akabas 2007). However, this should not be a substitute for the essential need to include the consumer him or herself on the team.

Advocacy

People with mental illnesses can too often be subject to discrimination and other rights violations that can impact their clinical care. This ranges from breaches of confidentiality to abuses related to the use of seclusion and restraints. Peer specialists act as monitors and ombudspersons to ensure that consumer rights are respected in clinical treatment settings and other situations (National Association of Peer Specialists 2010). As also noted above, this includes addressing issues of stigma and discrimination.

Finally, peer specialists can assist with improving the quality of treatment by collecting, analyzing, and reporting measures of consumer feedback and satisfaction. This can include operating consumer satisfaction teams, administering surveys and developing consumer advisory boards (National Association of Peer Specialists 2010; Wallcraft et al. 2009).

Administrative Issues

Several administrative issues are important to address when establishing and sustaining peer specialist initiatives. First, the financing of peer specialists in public mental health systems can be arranged from various sources. As noted earlier, many states are now billing Medicaid for this allowable service (Daniels et al. 2009). Others use SAMHSA Mental Health Services Block Grants and others state general revenue funds. Some others are contracting for this service via managed behavioral healthcare organizations. The State Mental Health Authority—and in particular if one exists, the Office of Consumer Affairs within that entity—can be good sources of information on financing options. No matter what source, individuals should be compensated at a fair standard of wages comparable to similar positions. There should also be opportunities for career advancement—including supervisory and managerial positions—so that these do not become stagnant jobs (Daniels et al. 2009).

The recruitment and hiring of peer specialists can also be conducted through various sources. External consumer advocacy and support organizations, which exist in virtually all states, can be an excellent source. If individuals are recruited from within an organization, it is generally recommended that the person should receive his or her own mental health services in a different facility wherever possible (Chinman et al. 2008).

Peer specialists should undergo an initial and an on-going continuing education skill-based training and certification program. These are generally state-specific as a requirement for Medicaid billing. Training content should include the values, philosophies, ethics, and standards of peer support services and provides the competencies—including cultural competencies and trauma informed, whole health care—for peer specialists (Daniels et al. 2009; Chinman et al. 2008).

Employees who are peer specialists should be treated like all other staff of the organization and subject to all of the benefits and requirements associated with an organization's personnel policies. This includes reasonable accommodations for those who so request it. Most accommodations for people with mental illnesses—such as having a flexible schedule or taking time off for appointments—are very low cost and easily implemented (Job Accommodation Network 2010).

Challenges and Solutions

Stigma

One of the biggest challenges that peer specialists face is the degree of acceptance or lack thereof that they experience from other staff members. Issues of stigma, misperceptions, and lack of staff knowledge can fuel these experiences. Attitudes and behaviors can be difficult to change as peer specialists modify their role from patient to colleague. To help address this, it is important for all levels of staff to be educated on the roles and responsibilities of peer specialists. At the same time, peer specialists should be educated on the roles and responsibilities of other staff members. It is also important for leadership to act as champions of peer specialists and be clear and continually reaffirm their support for these efforts (Daniels et al. 2009; Chinman et al. 2008; Gates and Akabas 2007). At the same time, it is important that staff do not patronize or act paternalistically toward peer specialists. They should have the same performance expectations as any other staff member.

Relationship to the Team

Mental health recovery—and treatment—is predicated on honest, trust-based relationships. The same is true of the relationship between peer specialists and traditional mental health providers including psychiatrists. The absence of such relationships is detrimental to building an effective, collaborative, and interdisciplinary team to assist the consumer being served. As noted above, stigma and misperceptions can be barriers to effective relationships. While the preceding

focused on the stigma that peers may face, peer specialists themselves may also harbor unknowing misperceptions about traditional providers and in particular psychiatrists. The key to breaking down these barriers and building effective relationships is open and transparent interpersonal communication. Peer specialists and traditional providers should invest time in engaging in dialogue with one another about their values, roles, challenges, and goals. Such dialogue can both be formal—through facilitated roundtable meetings (Substance Abuse and Mental Health Services Administration 2000) or during staff meetings—as well as through informal conversations over a cup of coffee or at lunch.

It can be challenging for one individual to be the only person to staff such a position within a treatment organization. To avoid the potential isolation that this brings, it suggested that a minimum of two peer specialists be hired for any clinical team. Allowing opportunities for peer specialists to participate in peer support groups can also be helpful (Chinman et al. 2008).

If there is insufficient clarity on roles and responsibilities, peer specialists and other staff members can experience role conflict and confusion. It is important, as with any job, that clearly defined, formal position description be developed and communicated to avoid this pitfall (Daniels et al. 2009; Chinman et al. 2008).

Overidentification with "Provider" Role

A final challenge is the possibility that peer specialists overassimilate and take on the roles and responsibilities of traditional mental health providers. Individuals can take on the norms and operating practices of those that surround them. Taking on provider roles is counter to the very purpose of these positions—for individuals to use their lived experiences of mental illnesses to assist others in a nontraditional way of peer support, information, and advocacy. To prevent this, clear job descriptions and codes of ethics should be put in place. Supervision and on-going training can also reinforce the unique roles of peer specialists (Daniels et al. 2009; Chinman et al. 2008).

Conclusion

Peer specialists have emerged as a valuable asset to community psychiatry. The initiation and growth of this innovative approach is testament itself to the resiliency and strengths of people with mental illnesses to overcome obstacles and become productive, contributing members to our communities. This is the essence of recovery.

Further, their work clearly aligns with the ten fundamental components of mental health recovery as identified by SAMHSA's national consensus statement: self-direction, person-centered, empowerment, holistic, nonlinear, strengths-based, peer support, respect, responsibility, and hope (Substance Abuse and Mental Health Services Administration 2006).

This development also speaks to the collective growth and maturity of the mental health consumer movement. From its origins as an alternative to traditional mental health services, the consumer movement is now working in close partnership with providers.

Community psychiatrists have recognized the value that this new profession brings to their work. They are encouraging the expansion of peer specialists by supporting and championing peer specialists within their organizations and treatment settings. In the future, we will see peer specialists working in partnership with clinicians in all treatment settings throughout our communities—together striving for a common goal: to facilitate mental health recovery for those we serve.

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Telepsychiatry and e-Mental Health

11

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Introduction

The science fiction author Arthur C. Clarke wrote "The only way of discovering the limits of the possible is to venture a little way past them into the impossible…and any sufficiently advanced technology is indistinguishable from magic." Mr. Clarke's laws of prediction capture the romance of e-mental health. More concretely, telemedicine (direct patient care) and telehealth (medical records, preventive medicine training) both describe the use of medical information exchanged from one site to another via electronic communications to improve patients' health status, generally via the Internet or telephony.

The "magic" of e-mental health occurs by using teleconferencing, described in the American Telemedicine Association's *Practice Guidelines for Video-Conferencing for TeleMental Health* as "electronic communication between multiple users at two or more sites which facilitates voice, video, and/or data transmission systems: audio, graphics, computer and video systems" (Grady et al. 2009a). At first glance, it might appear that community psychiatry and telemental health might not be commensal, as we traditionally think of the community psychiatrist as working directly in the community served, using a physical connection with the environment, even reaching outside the traditional office, as integral to community-based care.

This chapter will illustrate how telemental health may actually better actualize the concept of the community mental health professional.

Practical Advantages of Telemental Health

First, telemental health can make the clinician more adaptive and more flexible to the service needs of the community. This is done by providing services to persons who have poor access to mental health services, i.e., patients living in frontier, rural, or medically underserved urban areas, as well as patients with physical disabilities impairing movement, patients below the poverty line, patients who are incarcerated, and those who reside overseas (Smith and Allison 2002).

Second, modes of communication are forever evolving in new directions. Readily available videoconferencing systems can provide high-definition communication between patient and provider, providing a virtual "face-to-face encounter" that is acceptable to both parties.

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Additionally, mental health patients and clinicians are increasingly using email, text messaging, as well as internet chat rooms, forums, phone counseling, e-therapy, online workbooks, Facebook, and Twitter (Kane and Sands 1998). Social networking is now commonplace, and for children, adolescents, and young adults, is as integral to being "social" as going out to parties or a meeting of friends at someone's house.

Third, community psychiatrists work in community settings other than mental health clinics and frequently facilities and organizations do not need full-time psychiatrists, or they might only need psychiatrists primarily for consultation to primary care physicians. Telehealth makes it possible for community psychiatrists providing services by interactive videoconferencing to work at multiple institutions in the same day, across hundreds if not thousands of miles. A psychiatrist may do a morning clinic at a jail, 2 h of consultation to an internist at a Federally Qualified Health Center, followed by 2 h of seeing emergency patients for a mobile crisis outreach team. Services can be delivered by a prearranged schedule or requested when need arises and be provided on-demand. This allows a variety of community-based institutions to better manage their dollars by purchasing mental health clinician time in the amount needed, when needed, and delivered to the patient location.

Finally, community and public mental health also involves treatment planning, education, and training components. Telehealth technology can bring together usually distant parts of a treatment team to do treatment planning or case conferences, for instance, to a counselor at school, a clinic psychiatrist, or family members at home. In this way, treatment can progress more quickly, efficiently, and problem issues such as splitting of treatment team members can be avoided more easily. Outreach can be done to local agencies to provide psychoeducation and prevention-oriented interventions. Distance learning setups can allow literally hundreds of participants to view and interact with a central presenter. Training and clinical supervision can be done to psychiatric residents, nurses, social workers, psychologists, and other disciplines, individually or in group and at one or multiple training locations.

History of Telemental Health

The suitability for telemedicine in psychiatric practice did not escape early pioneers in telemedicine. In 1956, Cecil Wittson of the Nebraska Psychiatric Institute (Wittson et al. 1961), in the journal *Mental Hospitals*, described using one way, closed circuit television transmission to provide psychiatric training to students at the Medical College of Nebraska. In 1957, the instructional network was expanded to Iowa, North and South Dakota with ability to transmit audio in both directions. Simultaneous audio and video transmission debuted in 1959 with subsequent improvement in consultation, diagnostic assessment, and even group psychotherapy.

In 1968, the National Institute of Mental Health funded the first microwave relay resulting in direct consultation at a patient's locale. This feat was accomplished by Dartmouth's Department of Psychiatry to a rural affiliate hospital. In addition, the technology interface allowed for clinicians to operate the equipment themselves. Dwyer described a project in 1973 in which psychiatrists from the Massachusetts General Hospital used closed circuit television to see patients at the nearby airport (Dwyer 1973). This project was noteworthy for the first use of the term "telepsychiatry" and the use of remote controlled cameras to pan, tilt, and zoom.

Since the mid-1970s, telepsychiatry has gradually expanded in acceptance and become more embedded in community psychiatry networks as obstacles have slowly been overcome. These obstacles include licensing across state lines, limited reimbursement by insurers, lack of efficacy studies, uneven availability of sufficient bandwidth, ease of use of equipment and lack of available technical support, cost of videoconferencing equipment, and robust privacy protection. It is important to note that patients have been accepting of the use of telepsychiatry, in fact more so than psychiatrists, who have often been quick to doubt that therapeutic relationships can develop via the television (Bishop et al. 2002; Simpson et al. 2001a; Tilford et al. 1997).

With the availability of web-based videoconferencing programs and safe and secure transmission over the Internet now available, the demand for both telemental health diagnosis and treatment will likely continue to grow.

Telemedicine Technology and Environment

For many clinicians interested in telemedicine, the idea of having to learn to use so much new technology is daunting. In practice, the equipment is no more complicated to use than a home remote control for a television once initial installation, configuration, and available technical support is provided. Telemedicine technology has evolved from early use of two-way phones, to one-way videoconferencing, then to two-way interactive videoconferencing, and finally to technologies such as faxing, email, texting, instant message programs, chat rooms, and internet forums.

One of the very latest forms of technology is asynchronous interviewing in which the interview is recorded at one location using a clinical assessment tool such as a SCID (Spitzer et al. 1992), with the archived interview viewed by a psychiatrist at a later time to diagnose and offer treatment recommendations (Yellowlees et al. 2010). Telepsychiatrists are also guiding robots with video monitors through the hallways of hospitals to make rounds on patients, controlled by a joystick connected to their office computers.

Designing and Implementing a Telemedicine Network

Technology

A full review of technology hardware and software is beyond the scope of this chapter, so what follows is a brief introduction to the design and implementation of a telemedicine network. The first step in developing a telemedicine service is choosing appropriate videoconference systems. A variety of manufacturers offer videoconference devices, which range widely in cost and features. Industry standards for the transmission of audio and video signal allow devices from different makers to connect and communicate. Systems may be designed for a single desktop user or for large conference settings. Cameras may be fixed or pan-tilt-zoom adjustable. The design of any telemedicine delivery system must take into account needs of both patient and practitioner. Treatment team meetings and family sessions necessitate use of systems, which can zoom out to view multiple individuals. Design of systems for wider medical uses may incorporate digital stethoscopes and exam cameras. Well-designed systems plan for immediate and future uses, expected life of a project, expansion of volume or scope of services, and budget.

The second step is network choice. Today, telemedicine can be practiced over private digital networks or over the open internet using transfer technologies that most community psychiatrists are familiar with: T1 lines, cable, digital subscriber line (DSL), and integrated services digital network (ISDN) (Harte 2007). Satellite teleconferencing remains expensive and impractical for routine telemedicine programs. Determination of bandwidth requirements and Quality of Services (QoS) is integral to successful telemedicine design. Bandwidth refers to the amount of information, or data that can be carried by the digital pipeline in use. QoS refers to a pipeline's capability to transfer certain types of data more efficiently. With regards to telemedicine, this means prioritizing bandwidth so that audio and video data gains precedence over email and other electronic file types. Higher QoS means more detailed images and audio, free of pixilation, frozen screens, or dropped calls. QoS is better over private networks where bandwidth is guaranteed and multiple users are not trying to use the digital pipe at the same time (American Telemedicine Association Telemedicine Technology Summit Telemedicine/Telehealth Terminology 2010).

Bandwidth is measured on the high end in megabits per second and on the low end in kilobits per second. It is important to contract for a guaranteed bandwidth to avoid fluctuation in the quality of the audio and video signals. If not, the result is degraded call quality characterized by

large pixels, truncated audio, and errors in lip synchronization, easily the single greatest detractor from the experience that the telemedicine encounter matches in-person care.

American Telemedicine Association (ATA) guidelines (Grady et al. 2009a) for technical specifications recommend transmitting data at a minimum of 384 Kbps, or a speed necessary "to allow the minimum smooth and natural communication pace necessary for clinical encounters." The American Psychiatric Association also recommends a high quality minimum transmission speed of 384 Kbps, noting that it improves the recognition of negative symptoms of schizophrenia, tremors, and pupillary reflexes, and improves patient and psychiatrist satisfaction (American Psychiatric Association Resource Document 1998). In rural areas, speeds may not be available beyond 384 Kbps. However, it remains unclear if faster speeds result in better clinical outcomes in telepsychiatry. The most important factor is full, constant 30 frames per second transmission, free of jitter and transmission loss. With the drop in the cost of higher bandwidth, high definition teleconferencing (equivalent to the 720p and 1080p seen in television broadcasting) is becoming more affordable at prices starting under $5,000. With regards to audio, high quality microphones with 7 kHz full duplex and echo cancelation are necessary to catch the nuances in speech required to provide an accurate mental status examination.

Consulting Room Environment

There has been much discussion about the environment of the telemedicine consulting room. In general, the room should be treated as any mental health consultation room. There should be no unauthorized access and the room should be sound proof with no outside line of sight. All persons on and off camera at both locations should be identified and rooms should be well lit. The ATA Telemental Health Guidelines recommend 150 ft/candles of fluorescent light resembling natural daylight. Lighting should be placed to avoid shadows on patient and clinician. Backgrounds should be uniform of color and not distract from the face and body. The ATA recommends blue background as it "neither reflects [nor] absorbs light, is a calming color, and helps to accentuate the area of interest." Spoken language is better understood if carpeting, furniture with soft materials and edges, and wall mounted sound baffles are used in the telemedicine room.

Finally, it is important that both the patient and clinician appear to be looking each other in the eye. This can be done by designing and adjusting camera placement and angle relative to the display screen to provide optimal eye contact (Tam et al. 2007).

Legal and Ethical Considerations

Telepsychiatry raises multiple legal and ethical questions by nature of the different location of patient and community psychiatrist. Some issues are more concrete, such as licensure requirements for the physician. Other issues are more abstract, such as the nature of the doctor–patient relationship in a virtual encounter. Still others raise physician responsibility questions, such as the physician's actions in the case of interrupted patient care sessions.

Licensure and Credentialing

Licensure and credentialing were early legal obstacles to telepsychiatry. In general the issue pertains to the fact that states license physicians to practice in that state only; hospitals credential and privilege clinicians to practice as members of a defined medical staff. This makes it very difficult for a single psychiatrist using telepsychiatry to treat patients across state lines or in multiple, unrelated hospitals. Hyler and Ganger describe potential solutions to this problem (Hyler and Gangure 2004), including allowable out-of-state consultations with colleagues and limited reciprocity. As a matter of practice, however, telemedicine remains largely confined to physicians treating patients in states in which the doctor is licensed.

National registration exists for physicians employed by the Department of Veterans Affairs, Public and Indian Health Services, and Federal

jails (Legal Impediments to the Diffusion of Telemedicine 2010). As of late 2005, The Joint Commission (TJC) stated "licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating (patient) site" (http://www.jointcommission.org/AccreditationPrograms/Hospitals/telemed_requirements_hap_cah_delayed.html). TJC has created a "by proxy" situation whereby the patient site can accept the credentialing and privileging of the distant (psychiatrist) site if that site is TJC-accredited. The Federal Center for Medicare and Medicaid Services at the time of this writing is proposing regulations that would allow for streamlined credentialing of physicians by relying on interhospital agreements (Proposed rule, 42 CFR Parts 482 and 485 2011).

e-Security, Privacy, and Confidentiality

With regard to data security and privacy, the delivery of health care via telemedicine is subject to the Health Insurance Portability and Accountability Act (HIPAA) and state requirements found in applicable medical administrative codes (Health Insurance Portability and Accountability Act 1996).

HIPAA spells out the level of encryption that must be provided and divides security domains into administrative and technical safeguards. Administratively, e-mental health systems must allow for login monitoring and password security. From a technical perspective, there must be access authorization, encryption, and decryption of audio and video at a minimum 128-bit level. There must be audit control providing logs, login monitoring, and reports if someone tries to intrude on the real-time videoconferencing or EMR system (Health Insurance Portability and Accountability 1996). Encryption is defined as the encoding of a message to prevent unauthorized viewing of information. Prospective telemedicine providers should research encryption standards of any dedicated or computer-based videoconference system to determine that encryption methods meet HIPAA standards and are enabled during clinical encounters. The most common forms are Triple Data Encryption Standard (3-DES) and Advanced Encryption Standard (AES) (Xiao and Chen 2008). Community psychiatrists should ensure that one of these standards, preferably AES, is installed on any equipment used for e-mental health.

Confidentiality and privacy are important for both clinicians and patients. No recordings should be made either telephonically or via teleconferencing without consent. Safeguards must be taken to protect any e-mental health communications including email, instant messaging, and texting.

Informed Consent

It is important to address security, privacy, and confidentiality through informed consent (Stanberry 2006). Since there is little legal precedent in this area regarding telemedicine, a variety of informed consent forms have been developed. Such forms generally resemble a typical psychiatric informed consent template, with additional items that relate to telemedicine (see Table 11.1).

Malpractice

There is also little legal precedent for telemedicine malpractice. As always, malpractice hinges on whether there was a physician–patient relationship, whether the physician breached duty of care, and whether there was harm to the patient. There are early trends emerging with courts finding electronic communications as having met the criteria for physician–patient relationship if advice is given to and applied by the patient or the physician takes affirmative action with regard to patient care (Kansas Legal Code 2001). One clear trend is that doctors must follow state licensing requirements and must be licensed in the state the patient is physically in or risk prosecution and denial of coverage by their malpractice insurer (California Legal Code 2007).

Table 11.1 Informed consent elements related to telemedicine

My healthcare provider has explained to me how the videoconferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my healthcare provider.
I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that this video consultation is done over a secure communication system that is almost impossible for anyone else to access but that since it is still a possibility, I accept the very rare risk that this could affect confidentiality. I understand that my healthcare provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
I understand that the specialist needs a healthcare person sitting in the consulting room with me to assist in the consultation and to help provide for continuity of care.
I understand that my healthcare information may be shared with other individuals at my institution for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and the consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask nonmedical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.
I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting healthcare provider.
I understand that none of the consultation will be recorded or photographed.

Other liability issues have been raised as telemedicine matures as a medium of clinical contact, such as when information might be lost in transmission, leading to morbidity or mortality; when the interview is interrupted by technical difficulties and cannot be completed; and whether telepsychiatry is legally equivalent to face-to-face psychiatry. Litigation will inevitably settle these and other questions.

Evidence Supporting the Use of Telepsychiatry in Community Settings

With the current technology, telepsychiatry can be used to extend the reach of the community mental health system to a variety of settings. So far, telepsychiatry has been used in diverse settings such as rural mental health outpatient clinics, mobile outreach and assertive community treatment services, hospital and regional medical emergency rooms, school-based clinics, primary care clinics, psychiatric inpatient hospitals, crisis respite units, and freestanding mental health emergency centers (see Table 11.2).

There is a growing and encouraging evidence base demonstrating the effectiveness of telepsychiatry. There have been many studies and several excellent reviews over the past recent years demonstrating effectiveness for the delivery of mental health care in diverse settings, multiple countries (Simpson et al. 2003; Tang et al. 2001), and for a range of psychiatric disorders.

One challenge in reviewing the literature base is that the technology is evolving rapidly and adequately comparing studies may be difficult. For instance, interactive videoconferencing quality is highly variable but has been rapidly improving in regard to audio and video quality and in reliability. To date, there is little research at this point on providing home-based behavioral health treatments. Additionally, the bulk of the literature is based on grant-supported projects with robust budgets, enabling high quality videoconferencing environments with readily available technical support. It is not necessarily the case that clinical equivalence based on high definition videoconferencing effectively translates with similar efficacy to care on consumer-oriented computer systems with limited image size and resolution. However, as described below, while much remains to add to the evidence base for telepsychiatry, existing data do suggest that mental

Table 11.2 Common telepsychiatry locations

Community mental health centers (Norman 2006; O'Reilly et al. 2007)
Outpatient clinics
Day treatment programs
Partial hospital
Psychosocial rehabilitation programs
Psychiatric emergency services (Sorvaniemi et al. 2005; Yellowlees et al. 2008)
Psychiatric emergency rooms
Mobile crisis teams
Crisis stabilization units
Crisis residential/respite units
Crisis counseling unit
Walk-in crisis centers
Correctional services (Zaylor et al. 2000)
Jails
Court-ordered evaluation
Juvenile justice
Restoration of competency
Halfway houses
General hospitals (Sorvaniemi and Santamaki 2002)
Emergency departments
Intensive care units
Consultation-liaison
School-based mental health (Nelson et al. 2003; Young and Ireson 2003)
Skilled nursing facilities
Nursing homes
Rehabilitation facilities
Assisted living
State/private psychiatric hospitals (Mielonen et al. 2000; Pollard and LePage 2001)
State mental health living centers
Other
Airplanes, cruise ships
Offshore oil platforms
Overseas employees/active military

health diagnosis via interactive videoconferencing is comparable to that derived from in-person evaluation. A variety of treatment modalities and interventions have similarly shown equivalence when delivered by videoconferencing.

Clinical Services and Practitioners

On a practical level, it is useful to start most telemental health encounters by first asking the patient if they have seen a doctor on television before, followed by pointing out that "if we were together in the same office we would do exactly the same thing…just chat back and forth." More formally, in 2009, the American Telemedicine Association published *Evidence-Based Practice for Telemental Health* (Grady et al. 2009b), looking at types of clinical services, as well as the telehealth professionals delivering those services. The document noted certain broad points.

First, medication management is the most studied of telemental health service and the most common intervention. The psychiatrist's ability to deliver high quality, empathic care regarding the prescribing of psychiatric medications is the primary force behind a person's satisfaction and successful clinical outcomes. There is literature on child/adolescent, adult, geriatric, and forensic populations showing positive results for evaluation, efficacy, and patient/family satisfaction.

Second, there are a wide variety of assessments and laboratory studies that can be ordered by the psychiatrist doing remote assessment. These interventions include nurse-guided physical assessments (AIMS testing, vital signs, side effects), as well as laboratory and radiological tests. While there is a paucity of literature, the ATA notes that standardized diagnostic instruments, rating scales, and neuropsychological testing have been provided and studied using telemedicine.

Finally, there are few studies exploring the use of nurse practitioners (Tschirch et al. 2006) in telemedicine. Research into the use of physician assistants is limited to the use of telepsychiatry for clinical supervision by a psychiatrist (MacFarlane et al. 2006). Currently, research into social work-specific telemedicine interventions is also limited (McCarty and Clancy 2002) Studies have shown efficacy for psychological interventions delivered via telehealth including psychoeducation (Faulkner and McClelland 2002), as well as individual (Griffiths et al. 2006), group (Wittson et al. 1961), family (Hill et al. 2001), and couples (Patterson et al. 2004).psychotherapy. Regarding substance abuse services, the use of licensed chemical dependency counselors via telehealth has shown some success (Frueh et al. 2005; Ikelheimer 2005).

There is frequent discussion of what areas of mental health care are not appropriate for telemental health. Three areas are seclusion/restraint monitoring, medication over objection, and involuntary commitment (Price and Sapci 2007; Setterberg et al. 2003; Yellowlees 1997). The use of telemedicine for these more coercive procedures is very limited. Given the gravity of due process, these interventions will require more rigorous research to become more widely recognized and approved by regulatory bodies.

Diagnostic and Treatment Indications

Telepsychiatry has been used for several different conditions including depression, dementia, panic disorder, obsessive compulsive disorders, post-traumatic stress disorder, and child and adolescent disorders such as attention-deficit disorder, oppositional defiant disorder, and conduct disorder.

Depression

At least eight studies have demonstrated efficacy for depression treatment delivered via telepsychiatry (Andersson et al. 2005; Christensen et al. 2004; Clarke et al. 2005; Hunkler et al. 2000; Miller and Weissman 2002; Mohr et al. 2005; Pearson et al. 2003; Ruskin et al. 2004; Schopp et al. 2000). Ruskin et al. published a randomized controlled trial that showed no difference in depression outcomes delivered by either videoconferencing or face-to-face intervention. Results were additionally comparable regarding dropout rates and patient satisfaction ratings. In this study, telepsychiatry was, however, more expensive, but costs were comparable if psychiatrist travel expense to remote clinic locations was considered.

Dementia

There is a rapidly increasing evidence base for the effectiveness of neuropsychological assessment of dementia and other disorders delivered via teleconference (Clement et al. 2001; Hill et al. 2005; Jacobsen et al. 2003). There have been a variety of technologies as well as interventions studied for dementia treatment, from brief telephone-based cognitive screening (Wittson et al. 1961), videoconference-delivered outpatient psychiatric intervention for mild dementia (Poon et al. 2005), and videoconference-delivered nursing facility treatment (Johnston and Jones 2001), all demonstrating efficacy comparable to in-person care. In several videoconferencing studies, however, it was noted that physical guidance at the distant, patient care site was sometimes necessary to implement the interventions.

Panic Disorder, Phobic Disorders, Social Anxiety, Generalized Anxiety Disorder

Arguably the largest evidence base for telepsychiatry exists for the treatment of anxiety disorders. Many studies have shown efficacy for the delivery of cognitive behavioral and exposure treatment for these anxiety disorders as well as medication management. Cognitive behavioral therapy (CBT) studies are highly heterogeneous in protocol methodology and therapist involvement ranging from interactive internet-based interventions with brief therapist email follow up on one end of the spectrum to multiple full-length CBT therapy sessions delivered via teleconference (Andersson et al. 2009; Bergström et al. 2010; Bouchard et al. 2004; Carlbring et al. 2010). Most studies have shown efficacy and, when comparisons with face-to-face interventions have been done in studies, they have been shown to be equally effective.

There is a large potential for increasing patient access to care via videoconferencing or internet-based interventions for patients with panic disorder with severe agoraphobia. Since these patients have marked difficulty leaving their homes, bringing the initial interventions to them potentially increases their ability to receive treatment. In fact, agoraphobia may be an instance in which delivery of care through remote technology may be better tolerated by patients than traditional treatment. Informally, several CBT therapists have reported incorporating remote technology as part of exposure treatments for several years.

Obsessive Compulsive Disorder

There are limited outcome studies in the literature at present for the use of telepsychiatry for the treatment of obsessive-compulsive disorder (OCD) (Greist et al. 2002; Himle et al. 2006; Kenwright

et al. 2005; Tumur et al. 2007). In 2006, a pilot study for the videoconference delivery of CBT demonstrated efficacy. This is encouraging, given the limited number of well-trained therapists available for treatment of OCD, especially in rural areas. Similar to agoraphobia, telemedicine may provide some advantages to the initial delivery of telepsychiatry for a certain number of patients with OCD that have difficulty accessing traditional care because of their obsessive and compulsive symptoms.

Posttraumatic Stress Disorder

Research has shown treatment via remote technology to be at least comparable to face-to-face (Germain et al. 2009; Knaevelsrud and Maercker 2006, 2007; Lange et al. 2003a, b; Tuerk et al. 2010). In a 2007 secondary analysis of a randomized controlled trial comparing the effectiveness of manualized CBT via teleconferencing vs. face-to-face treatment found that therapist competence and adherence to CBT methodology was responsible for treatment effectiveness, not delivery method. A recent pilot study for prolonged exposure delivered via videoconference for 12 veterans with combat-related PTSD demonstrated significant improvement. Although this is a small study without randomized design, it is consistent with the larger literature.

Schizophrenia, Psychotic Disorders

Several studies have shown the efficacy of telepsychiatry for psychotic disorders to be comparable to face-to-face delivery of care, through internet-based, telephone, and videoconferencing interventions (Chae et al. 2000; Zarate et al. 1997). One randomized controlled trial showed that people with schizophrenia who received an internet-based approach showed that they reported lower perceived stress compared to those receiving care as usual.

Childhood Disorders

Treatment for children is relatively well represented in the literature base for telepsychiatry. However, most of these studies have not been outcome studies for specific disorders. There have been several studies suggesting that telepsychiatry consultation and treatment for child and adolescent disorders are comparable to face-to-face intervention in diagnostic validity, with a high degree of patient and family satisfaction (Diamond and Bloch 2010; Nelson et al. 2003). Settings as diverse as correctional facilities, rural mental health clinics, and school clinics have been described in the literature (Fox et al. 2008; Kopel et al. 2001; Young and Ireson 2003). It has even been argued recently that for certain child and adolescent patients, telepsychiatry is potentially preferable to face-to-face consultation (Pakyurek et al. 2010).

Patient Satisfaction

Studies on satisfaction have been quite variable with regard to patient population, type of telepsychiatry technology, and results. There have been several studies comparing telepsychiatry to in-person care, but relatively few have approached the question in a prospective manner (Callahan et al. 1998; O'Reilly et al. 2007). Relatively consistent findings suggest that patients generally prefer a telepsychiatry appointment close to home as an option to an in-person appointment requiring travel (Brick et al. 1997). Another relatively consistent finding is that patients report being more satisfied with telepsychiatry appointments than they expect to be prior to the appointment (Mair and Whitten 2000).

Predictors of patient satisfaction have yet to be fully elucidated, however. It would be expected that technological issues such as video/audio quality (e.g., frame speed and connection reliability), demographic factors (e.g., age, ethnicity, gender), cost, disorder-related factors (e.g., acuity, symptom severity), and availability of alternative face-to-face psychiatry appointments would all affect patient satisfaction. Currently, however, there is limited available data from which to draw.

Cost-Effectiveness

Despite 50 years of telepsychiatry, there are still many questions to be answered about cost-effectiveness. Telepsychiatry has direct costs

including equipment and its maintenance, operations, network development and monthly network access fees, program salaries at both ends, and supplies. Indirect costs include administrative overhead and support. Telemedicine may offset certain costs, including those associated with patient absenteeism from work and travel for both patients and practitioners in the absence of the telemedicine systems (Hyler and Gangure 2003). Hidden costs include technical support, training individuals in the use of the equipment, maintaining duplicate records at host and distal sites, transmitting clinical information between sites, and space allocation for equipment.

In 2003, Hyler and Gangure reviewed the literature from 1956 to 2002 and identified 12 published studies on telepsychiatry that included cost analysis (Hyler and Gangure 2003). Analyzing direct, indirect, and hidden costs, the authors showed that in 7 of 12 studies telepsychiatry was worth the cost. One study determined that telepsychiatry was not financially viable for rural outpatients. Hyler identified three studies of cost-effectiveness which reported on the break-even number of consultations—the point at which the cost of telepsychiatry becomes equivalent to that of in-person psychiatry (Doze et al. 1999; Hailey et al. 1999; Simpson et al. 2001b). Most recently, Libby and colleagues analyzed the costs of doing structured psychiatric interviews for research purposes by telemedicine (Shore et al. 2007). In this study, the costs of doing interviews were initially higher due to setup costs and the purchasing of equipment, but costs were substantially less using telemedicine 2 years later.

In deciding whether telepsychiatry is cost-effective, much depends on whether the costs of the program are shared between participating agencies, amount and availability of reimbursement, and the cost of technical and infrastructure support. "Break-even analysis," the point at which the volume equalizes the costs of the telemedicine and face-to-face services, shows that higher volumes are required for cost-effectiveness. This can make it more difficult for rural programs to maintain fiscal solvency (Bose et al. 2001). When incorporated into larger healthcare contexts, telepsychiatry holds promise for both patient outcomes and healthcare costs by extending access, assessment, and treatment to populations that may otherwise require more expensive and restrictive care such as inpatient psychiatric hospitalization or boarding in a hospital emergency department. The existing literature on cost-effectiveness does not yet address the potential impact of telepsychiatry on larger system costs.

The Newest of the New: e-Therapy and Patient Communication

While a reasonable consensus is emerging on the acceptability and efficacy of mental health services provided via interactive videoconferencing, e-Therapy (or internet therapy) remains a controversial arena. The explosion of digital communication on a variety of devices and media has left few realms of human interaction untouched, and behavioral health is no exception. The rapid pace of development has challenged the mental health professions to consider the legal and ethical boundaries of practice as interaction with clients extends into new media and forms of communication. It is useful to separately address e-therapy from the consumer and the health professional perspective.

Consumers

Consumer-driven health care and access to information are a growing trend in the evolution of the US healthcare system. Widespread access to the Internet and the vast availability of health-related information have altered the consumer's relationship to medical information and to healthcare providers. It is not uncommon for people to present to their physician self-diagnosed with preferred choice of prescription medications already chosen. The consumer may be equipped with information of widely varying quality and applicability. As consumers have become accustomed to instant access to information and interaction via email, text messaging, and social media, expectations concerning use of these media have extended to their healthcare providers.

Information and interaction related to behavioral health is widely available on the Internet. For example, a growing number of websites provide contact information on practitioners, which may include ratings by patients. In terms of treatment, a Google search on the term "depression" identifies 54 million related sites as well as advertisements for local practitioners, treatment modalities such as trans-cranial magnetic stimulation, and depression support groups. Virtual support and information sharing groups are available by blog and social media. Searches related to psychotropic medications will access reasonably independent information clearing houses, proprietary sites sponsored by pharmaceutical manufacturers, and a host of blogs in which individuals share experiences, both positive and negative, about a variety of medications.

Many complementary and nontraditional interventions are available to consumers for relief from psychological symptoms, with evidence base ranging from nonexistent to anecdotal to robust and, increasingly, electronic media are the platform by which information, access, or guidance is available. In an arguably litigious society, the limits of personal responsibility and accountability continue to evolve and people remain largely on their own to evaluate and choose alternative care for mental health problems.

Self-directed care delivered via the Internet is in early stages of empirical evaluation. A Swedish initiative (Andersson et al. 2005) evaluated outcomes from Internet-based cognitive CBT for depression augmented by "chat room" discussion/support groups, with a contrast group receiving access to the chat room condition only. Results showed the self-directed care offered significantly greater improvement than for patients in the control condition. The self-directed CBT condition was notable for a significantly higher dropout rate compared to controls. Treatment outcomes were not contrasted with a "care as usual" condition provided via face-to-face therapy or medication. While largely self-directed, this study included patient screening via standardized rating scales and therapist feedback during treatment.

Self-directed care can only be expected to grow, given the ubiquitous growth of the internet and social media. Risks and benefits will be difficult to evaluate as individual consumers seek out e-therapies as full alternatives or complements to professional-directed care, but the trend promises to profoundly alter access to resources and relationship of client/consumer to mental health professional.

Healthcare Professionals

The mental health professional evaluating the uses and boundaries of electronic media remains in relatively uncharted waters. At the clearest end of the spectrum, many practitioners have developed web sites, which provide practice information including descriptions of academic background, experience, and areas of competence, specialization, and practice focus. Additional information may be provided on disorders or therapeutic approaches, as well as links to advocacy organizations or other information sources. As long as unsubstantiated claims for cures are not provided, such sites and means of communication are relatively uncontroversial and low-risk for practitioners.

When the practitioner enters the realm of e-healthcare for individuals, the boundaries of practice and guidance from licensing bodies become increasingly unclear and subject to interpretation. The American Psychiatric Association's Annotations to Medical Ethics (The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry 2010 Edition, American Psychiatric Association 2010) does not directly address the provision of care via telemedicine or other electronic means, but instead stresses the need for privacy and data security related to electronic storage of confidential information. The American Psychological Association's Ethics Code (Ethical Principals of Psychologists and Code of Conduct 2010) does not have prohibitions on delivery of services via electronic means. The operative standard, in the absence of specific rules regarding "electronic media," states: "In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable

steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm."

Additional language addresses privacy: "Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality." Interaction with the public is addressed as follows: "When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient."

When a professional relationship has been established, the healthcare provider must consider the balance of benefits and risks to the patient in extending traditional practice via electronic media. A therapeutic relationship, developed either in person or via interactive videoconferencing, may be reasonably extended via telephone sessions or emails in order to provide continuity of care or to facilitate therapeutic goals (e.g., intersession homework). The arena of controversy centers on the efficacy and safety of therapeutic relationships, which do not originate in face-to-face, real-time encounters. Establishment of a doctor–patient relationship in the absence of the ability to authenticate the identity and location of the patient, much less provide for adequate assessment and diagnosis, frames the pitfalls of e-therapy from the practitioner standpoint.

In 2003, Welfel reviewed all then-existing web-based e-therapy sites and concluded, "There is no theoretical base or scientific evidence of efficacy" in e-therapy, so it must be regarded as nothing more than an "experimental treatment with uncertain risks and benefit" (Welfel 2003). While doubt and controversy remains on the merits of e-therapy, delivery of internet-based or internet-assisted therapy continues to grow. The International Society of Mental Health Online (ISMHO) has developed a set of principles related to online provision of services (Chae et al. 2000). These principles address a range of topics including confidentiality and the limitations of confidentiality, evaluation of clients, and emergency backup. ISMHO also has a group of online therapists who study, review, and consult on a variety of online therapy cases (Suggested Principles for the Online Provision of Mental Health Services 2000).

e-Therapy as Adjunct

When assessment, treatment contract, and therapeutic relationship have been established in face-to-face encounter, the addition of e-therapy methods can broaden therapeutic approaches, provide on-going client assessment of progress, and leverage professional resources. Web-based systems such as "My Mood Monitor" invite clients to track mood symptoms and share information with healthcare providers if decided by patient (Gaynes et al. 2010). The National Center for Telehealth and Technology has deployed a similar system, T2 Mood Tracker 2010, a smart phone application for service members that tracks emotions and stress, with capacity to forward to a treating professional. The US military has also been a leader in development of virtual reality devices providing exposure therapy for PTSD (Rizzo et al. 2009). Some proponents of online therapy, such as Yellowlees, maintain that it enhances the therapeutic relationship, allowing clinicians to monitor treatment and keep up the momentum with homework assignments, reviewing the homework prior to the actual sessions (Yellowlees 2002). Yellowlees argues persuasively that online therapy can be invaluable in monitoring behavior during a crisis, including establishing regular communication with family members or other caregivers. He also posits that online therapy may enhance the therapeutic alliance by allowing for an increased number of therapy sessions (especially asynchronous email exchanges), thus providing "object constancy." He also says that because clients have more access to therapist time online, they may actually experience an enhanced "holding environment" in which they feel more cared about simply because

they are given more attention. Online therapeutic relationships also give a person the ability to "contact" the therapist whenever he or she wants and needs to, without fear of interrupting or being a nuisance. This might even facilitate the disclosure of more information at an earlier stage in the therapeutic relationship. From the perspective of the patient, Martha Ainsworth documented her personal experience with e-therapy. Of note to clinicians, she indicated that the anonymity of the process helped her gain the necessary confidence to move to another level of communication with her therapist (Ainsworth 2002).

Online therapy has the potential to reach individuals who might not otherwise have access to any such intervention, including the following: (1) homebound individuals, (2) rural populations, (3) agoraphobic individuals, (4) individuals who will not access in-person services due to shame/guilt, (5) individuals who travel extensively, and (6) individuals who are comfortable with e-communication who would not otherwise access services.

Practitioner adoption of audio/video communication with patients is in a phase of rapid flux, with the availability of low cost, even free video systems (e.g., Skype) accessible to professionals and consumers alike. Migration to such platforms may greatly increase adoption of telemedicine encounters, driven by individual practitioners as contrasted with the organization-driven prior history of telemedicine. This broader access on the positive side may represent a "democratization" of telemedicine, unfettered by need for grants, IT departments, and expensive technology. On the other hand, practitioners may adopt low cost devices and methods that have been insufficiently vetted for healthcare-grade reliability, patient privacy, and HIPPA compliance.

Conclusion/Future

Communication via electronic media continues to accelerate as we finish the first decade of the twenty-first century. Psychiatrists are beginning to explore, through experience and research, the boundaries of using telemedicine, email, text messaging, and other modes of electronic communication. Community psychiatry is well suited to these media, allowing the community psychiatrist to more rapidly access a wider range of urban and rural clinical programs, many in underserved areas.

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12 Traumatic Stress in the Community: Identification and Intervention

Paula G. Panzer, Elizabeth Snipes, and Caroline Peacock

Introduction and Definitions

Descriptions of *trauma*—an experience that overwhelms an individual's ability to cope and elicits feelings of terror, helplessness, and/or out-of-control physiological arousal—have appeared in popular, historical, and medical texts for centuries. The relevance of *traumatization* (i.e., when "both internal and external resources are inadequate to cope with external threat") (van der Kolk 1989, p. 393) to normal and impaired functioning is described in great detail in social, neuropsychological, and political texts. This chapter summarizes the current understanding of *traumatic stress* (i.e., the physical and emotional responses to events that threaten the physical or psychic integrity of an individual) and *traumatic stress disorders* and the evidence for effective intervention. Prevention of trauma, the ultimate effective community intervention, is best described in other texts.

Within a clinical context, there are two broad categories of trauma: those that are "man-made," or caused by the actions of person(s), and those that are "natural," in which the source is out of human control. Some traumas can fall into either category, depending on the circumstances, such as fires, car accidents, and medical trauma.

Formal recognition of the psychological effects of trauma exposure and the distinct persistence of symptoms in some individuals did not occur until the 1980s. Historically, soldiers had experienced what was known as "shell shock" or "battle fatigue." In 1980, studies documenting a reliable pattern of symptoms (to traumas beyond combat exposure) led to the classification of these experiences as post-traumatic stress disorder (PTSD) (American Psychiatric Association 1980). PTSD is diagnosed 1 month after trauma exposure when accompanied by symptoms in three categories—reexperiencing, avoidance/numbing, and hyperarousal—and the presence of clinically significant distress or impairment.

Symptoms of PTSD can be seen in almost all people in the immediate aftermath of traumatic exposure (Yehuda and LeDoux 2007). They are the result of adaptive physiological and psychological processes that protect the organism from threat and danger. The normal process of recovery after exposure leads to spontaneous remission of all symptoms within 1–3 months. PTSD can be seen as an inability of the organism to recover from the physiological and psychological effects of trauma (Yehuda and LeDoux 2007).

In recent years, clinicians and researchers have recognized some diagnostic and therapeutic limitations in the construct of PTSD, particularly for

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children and those exposed to ongoing or multiple traumas. An additional disorder, *Developmental Trauma Disorder*, may better explain the disruptions in multiple domains; studies of the accuracy and reliability of this profile are underway. The disorder stems from trauma that is interpersonal in nature, such as child abuse, sexual abuse, or family violence (van der Kolk 2005). A range of somatic, affective, cognitive, and relational dysregulation occurs, leading to disruption in functioning in multiple domains, including education, peer relationships, and behavioral control.

Chronic stress is defined as a series of ongoing phenomena that cause distress, anxiety, and difficulty; examples include racism, poverty, and homophobia. *Chronic traumatization* is the experience of multiple traumatic events—for example, a person is exposed to domestic violence and neglected as a child, is involved in a car accident as a young adult, and then is exposed to combat. The effects of chronic trauma are cumulative, as events serve to remind the individual of prior trauma and reinforce the negative impact. Chronic stress with single trauma exposure, chronic trauma, or some combination may result in *complex trauma*. Complex trauma affects nearly every aspect of development and functioning, including problems with attachment.

Epidemiology

More than 75% of persons in the United States are exposed to at least one traumatic event in their lifetime, and approximately 6.8% of those persons will be diagnosed with PTSD (Breslau and Kessler 2001; Kessler et al. 2005). While PTSD is defined in part by exposure to a traumatic event, only a small percentage of persons with traumatic exposure go on to develop the disorder.

Resilience and Risk Factors

A number of internal and external factors contribute to having risk for or inoculation against development of a trauma-related disorder. Event characteristics that affect trauma recovery include severity of the traumatic stressor and trauma type, with rape, assault, and combat leading to PTSD more often than natural disasters or man-made accidents (Yehuda and LeDoux 2007). Individual risk factors for PTSD include preexisting traits, including lower IQ, avoidant personality, and behavior problems, and pre- or post-traumatic life events, including childhood abuse, poor social support, and personal trauma history (Haglund et al. 2007; Yehuda and LeDoux 2007). Factors associated with resilience include positive emotions, active coping style, cognitive flexibility, a moral compass, and adequate social support (Haglund et al. 2007). Exposure at a young age to manageable levels of stress also helps to inoculate the organism from the effects of future stressors (Haglund et al. 2007).

Neurobiological Factors

Recent research has elucidated a number of known biologically based factors that influence an individual's response to traumatic exposure. Other risk and resiliency factors have been hypothesized based on current neurobiological research. A summary of these findings is presented in Table 12.1.

Assessment

A comprehensive assessment is one of the most important aspects of mental health care. All people seeking services should be assessed for trauma exposure, symptoms, disorders, and disruptions in functioning. Direct, trauma-specific assessment is crucial in providing effective trauma-related care. Assessment should be done after building an initial rapport and should be targeted and thorough, gathering information necessary to fully inform the most effective course of treatment.

Assessment can be done through informal clinical interviewing, structured clinical interviewing, and the use of objective assessment measures. There are numerous empirically validated structured clinical interviews and objective assessment instruments. Table 12.2 displays some of the most widely used measures with well-established psychometric properties.

Table 12.1 Neurobiological factors

Endogenous agent/brain structure	Hypothesized effect on risk/resilience
Amygdala	Hyperactivity of the amygdala associated with post-traumatic stress disorder (PTSD) (Yehuda and LeDoux 2007)
Medial prefrontal cortex (mPFC) and dopamine	PTSD associated with reduced activity of mPFC
	Decreased release of dopamine in mPFC may delay extinction of conditioned fears (Haglund et al. 2007)
	Resilience associated with reward systems that are "hypersensitive to reward or resistant to change" (Haglund et al. 2007 p. 903)
Hippocampus	Small hippocampal volume/decreased hippocampal function associated with increased risk for PTSD (Yehuda and LeDoux 2007)
Cortisol	Many studies have shown decreased levels of basal cortisol in people with PTSD (Haglund et al. 2007)
	Decreased levels of cortisol could place people at risk for developing PTSD (Haglund et al. 2007; Yehuda and LeDoux 2007)
	Overall findings on the role of cortisol and PTSD are somewhat contradictory (Haglund et al. 2007)
Corticotropin-releasing hormone (CRH)	Excessive stress in early life may result in increased CRH activity
	Resilience likely associated with effective regulation of CRH (Haglund et al. 2007)
Neuropeptide Y (NPY)	"Counteracts anxiogenic effects of CRH" (Haglund et al. 2007 p. 900)
	Low levels of NPY associated with PTSD (Haglund et al. 2007)
Serotonin	"Short allele for serotonin transporter protein results in less serotonin production than the long allele" (Haglund et al. 2007 p. 902)
	People with PTSD much more likely to have the short/short allele (Haglund et al. 2007)
DHEA	Enhances cognition and performance under stress (Haglund et al. 2007)
	High levels appear to be related to recovery from stress

Interventions

Trauma interventions occur on system and service levels. On a service level, a practitioner may use various interventions to treat PTSD. For example, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) may be used in an outpatient treatment setting for children with PTSD. On a systems level, there are several evidence-based, trauma-informed models of care, such as the Sanctuary® Model (Rivard et al. 2003) and Trauma Systems Therapy (Saxe et al. 2007). These include a whole-system approach encompassing multiple layers of trauma understanding and intervention.

Trauma-informed services are not specifically designed to treat trauma-related symptoms or syndromes (Marsenich 2010). Rather, Trauma-Informed Care supports delivery of Trauma-Specific Services (Hopper et al. 2010). All aspects of service in a trauma-informed system of care (TISC) are influenced by an understanding of the role of violence in the lives of people served by community agencies. Services accommodate the potential vulnerabilities of trauma survivors so as to avoid inadvertent re-traumatization and facilitate consumer participation in treatment. TISCs also require collaborative relationships with service system partners, including child welfare, legal aid, and substance abuse agencies (Marsenich 2010).

Intervention Selection

There is an extensive body of research consisting of large, methodologically sound randomized controlled trials examining the effectiveness of various treatment interventions for PTSD in adults. Meta-analyses of these individual studies indicate that cognitive behavioral approaches, including exposure therapy, trauma-focused cognitive therapies, eye movement desensitization reprocessing (EMDR), and anxiety management

Table 12.2 Assessment instruments

Instrument	General classification	Description	Population	Special considerations	Diagnostic category
The Clinician-Administered PTSD Scale (CAPS)	Structured clinical interview	Assessment of the 17 symptoms of PTSD derived from DSM-IV diagnostic criteria plus impact on social and occupational functioning, overall PTSD severity, and response validity	Adults	Considered the gold standard for adults, can take over an hour to administer (Briere 2006)	PTSD
The Structured Clinical Interview for DSM-IV (SCID) PTSD module	Structured clinical interview	The PTSD module in the SCID-I assesses for symptoms of PTSD based on DSM-IV diagnostic criteria	Adults		PTSD
Posttraumatic Stress Diagnostic Scale (PDS)	Self-report	Assessment of the 17 symptoms of PTSD derived from DSM-IV diagnostic criteria plus level of symptom interference in daily life	Adults	Not normed on general population, no *T*-scores (Briere 2006)	PTSD
PTSD Checklist-Civilian Version (PCL-C)	Self-report	Assessment of the 17 DSM-IV PTSD criteria during the last month, PCL-C refers subject to general trauma, PCL-S refers to a specific event	Adults	Military version (PCL-M) refers to combat-related trauma	PTSD
Trauma Symptom Inventory (TSI)	Self-report	100-Items, 3 validity scales, and 10 clinical scales assess level of post-traumatic stress over previous 6 months	Adults	Often used to assess complex PTSD (Briere 2006)	PTSD
UCLA PTSD Index for DSM-IV (PTSD-RI)	Self-report	Screens for exposure to traumatic events and assesses for all DSM-IV PTSD symptoms	Children (ages 7–12) and adolescent (13 and up) versions	Parent version allows for assessment from another source	PTSD
Trauma Symptom Checklist for Children (TSCC)	Self-report	Assessment of trauma-related symptoms, two validity scales, and six clinical scales	Children and adolescents (ages 7–17)	Comes in abbreviated or full-length form	PTSD
The Acute Stress Disorder Interview (ASDI)	Structured clinical interview	19 Items assessing dissociation, reexperiencing, avoidance, and arousal	Adults	Brief administration time (Briere 2006)	Acute Stress Disorder (ASD)
Acute Stress Disorder Scale (ASDS)	Self-report	19 Items assessing ASD symptoms that correlate with clusters measured by the ASDI	Adults		Acute Stress Disorder (ASD)
The Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D)	Structured clinical interview	Assesses presence of five dissociative symptoms including, amnesia, depersonalization, derealization, identity confusion, and identity alteration (Briere 2006)	Adults		Dissociative Identity Disorder
Adolescent Dissociative Experiences Scale-II (A-DES)	Self-report	30 Items assessing dissociative amnesia, depersonalization, derealization, dissociated identity, and dissociative relatedness	Adolescents ages 11–18	Brief administration time	Dissociative Identity Disorder

(AM), are all effective at treating PTSD (Bradley et al. 2005; Bisson and Cohen 2006; Cahill et al. 2006; Foa 2009).

Historically, research has indicated that no single cognitive behavioral approach is more effective than any other, and no combination of these approaches is more effective than any one cognitive behavioral treatment type alone (Bradley et al. 2005; Cahill et al. 2006; Foa 2009). In a recent study, however, Cloitre et al. (2010) found that combined skills training plus exposure therapy (STAIR/Exposure) was superior to supportive counseling plus exposure therapy on a number of domains, including attaining and maintaining PTSD-negative diagnostic status, reducing PTSD symptoms and anxiety, and improving emotion regulation, anger management, and interpersonal interactions. The authors postulate that exposure therapy may demonstrate its "maximum benefit" immediately following treatment, while combined therapies, such as STAIR/Exposure, continue to have an effect over time and lead to greater maintenance of symptom remission. When examining exposure therapy specifically, evidence is strongest for combined exposure: "imaginal" plus "in vivo" (Foa 2009).

Treatment of PTSD has been conceptualized as occurring in three phases: stabilization, resolution of traumatic memory, and integration. Phase One focuses on ensuring client safety, providing psychoeducation, and actively assisting the client in building skills for effectively coping with trauma-related symptoms. Phase Two consists of exposure to traumatic material through imaginal or in vivo exposure and often includes the writing of a trauma narrative. Cognitive processing is used to restructure trauma-related maladaptive thoughts and beliefs. A number of trauma-focused treatments use prolonged gradual exposure throughout all three phases of treatment. Personality integration and rehabilitation are the focus of Phase Three. The goal is to help the client return to fully functional daily living and enhance future safety (van der Hart et al. 2001).

A number of trauma-focused treatment models have been developed for adults, adolescents, and children, all of which are grounded in cognitive behavioral techniques. These models follow the three-phase paradigm, though some emphasize one particular phase over others. Most of these models utilize individual therapy; relatively few studies have examined group protocols. The small body of research available on group treatment indicates that it is not more effective than individual therapy (Foa 2009). Research indicates that of all trauma types combat-related PTSD is least responsive to treatment (Bradley et al. 2005). Little research exists on the effectiveness of treatment approaches not based on cognitive behavioral techniques, such as psychodynamic therapies and client-centered/humanistic approaches. Some of the most widely studied and well-supported trauma-focused treatments are summarized in Table 12.3.

Treating PTSD and Comorbid Behavioral Health Disorders

The prevalence of PTSD co-occurring with another mental health disorder is approximately 80% (Foa 2009). PTSD most commonly co-occurs with depression, substance abuse, and other anxiety disorders (Bradley et al. 2005). The occurrence of PTSD is also high among clients with personality disorders and those with severe mental illnesses (SMI), including schizophrenia, bipolar disorder, and treatment refractory major depressive disorder. As cited by Bradley et al. (2005), one study reports a 35% lifetime prevalence rate of PTSD among clients diagnosed with Axis II disorders, and Mueser et al. (2008) report that rates of PTSD range between 29 and 48% in SMI populations.

In addition, trauma-related symptoms are associated with increased severity of co-occurring SMI diagnoses (Freuch et al. 2009; Mueser et al. 2002). Mueser et al. (2002) hypothesize that the core symptoms of PTSD have a direct effect on the severity and course of SMI; for example, avoidance of trauma-related stimuli may lead to increased social isolation, and reexperiencing of trauma-related memories can be seen as a chronic stressor. PTSD also frequently co-occurs with substance use disorders, as trauma survivors often use drugs and alcohol to

Table 12.3 Trauma-focused therapies

Model	Population	Description	Modality
Exposure Therapy: Imaginal, In Vivo, or Combined	Adults	Exposure to traumatic material, either through imaginal imagery, in vivo/real-life exposure to trauma reminders, or combination of the two	Individual
Cognitive Processing Therapy (CPT)	Adults	A formalized treatment for adult PTSD, comprised of CT and exposure in the form of a written "trauma account"	Individual
Stress inoculation training (SIT)	Adults	A form of anxiety management, support is especially strong for female victims of sexual assault, support for use with veterans is mixed	Individual
Cognitive therapy (CT)	Adults	Cognitive processing and restructuring of maladaptive trauma-related thoughts and beliefs	Individual
Eye Movement Desensitization Reprocessing (EMDR)	Children, adolescents, and adults	An 8-stage treatment focused on assessment, desensitization, reprocessing, and replacement of cognitions	Individual
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Children and adolescents	The most widely researched of all treatment interventions designed for use with children and adolescents, a component-based model that follows the three-phase treatment paradigm, includes skill-building, CT, and a written trauma narrative	Individual, parent, and joint parent–child sessions
Trauma Systems Therapy (TST)	Children and adolescents	Focus on the social-environmental factors contributing to trauma-related problems, interventions focus on the family, school, and community	Individual and family therapy, office- and community-based
Seeking Safety (SS)	Adolescents and adults with comorbid substance abuse	Consists of 25 topics that can be addressed in any order, focused on establishing client safety, no direct exposure components	Individual or group
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Children and adolescents	Follows the three-phase treatment paradigm, includes skill-building, CT, and exposure	School-based group modality includes some individual and parent sessions

avoid reminders of trauma. Substance use disorders have long been associated with negative outcomes in SMI populations, and substance abuse increases the likelihood of further trauma victimization.

Research on the concurrent treatment of PTSD with co-occurring disorders is fairly limited. Seeking Safety, which targets the treatment of PTSD with comorbid substance abuse, is the only co-occurring treatment model that currently meets criteria for an efficacious evidence-based practice (Foa 2009). Based on the limited information currently available, it is recommended that clients presenting with PTSD plus comorbid conditions be treated using an evidence-based trauma-focused approach while simultaneously integrating additional components targeting specific co-occurring diagnoses (Bradley et al. 2005; Foa 2009).

Debriefing

The effectiveness of individual psychological debriefing (PD) and group debriefing, including Critical Incident Stress Debriefing (CISD), has been debated for many years. Current research indicates that individual PD is not effective at reducing symptoms of or preventing PTSD, and therefore is not recommended for use following exposure to a traumatic event (Bisson and Cohen 2006; Foa 2009; National Institute for Clinical Excellence 2005). Much of the research on CISD is marked by flaws in study design and misuse of the CISD model (National Institute of Mental Health 2002; Robinson 2008). A critical examination of all available studies indicates that group-based CISD is also likely not effective and not recommended for use following traumatic exposure (Foa 2009; National Institute for Clinical Excellence 2005).

Table 12.4 Psychopharmacological agents used in PTSD

Medication	Recommendations for use
Selective serotonin reuptake inhibitors (SSRIs)	Considered first-line pharmacological intervention for noncombat-related PTSD (Foa 2009; U.S. Department of Veterans Affairs National Center for PTSD 2010)
	Paroxetine and sertraline are most studied, most prescribed, and the only FDA-approved medications for treatment of PTSD (Berger et al. 2009)
	Recent randomized controlled trials indicate that SSRIs may not be effective at treating combat-related PTSD and suggest that pharmacological alternatives needs to be explored (Sullivan and Neria 2009)
Serotonin and norepinephrine reuptake inhibitors (SNRIs)	Venlafaxine ER is the only SNRI studied to date (Davidson et al. 2006)
	Results indicate that it is equally effective at treating PTSD as SSRIs (Davidson et al. 2006; Foa 2009; U.S. Department of Veterans Affairs National Center for PTSD 2010)
Antiadrenergic agents	Prazosin shown effective for improving quality of sleep and reducing nightmares (Berger et al. 2009; Foa 2009)
	Results on the prophylactic effects of propranolol are inconclusive, not enough current evidence to recommend it as an effective preventative treatment (U.S. Department of Veterans Affairs National Center for PTSD 2010)
Atypical antipsychotics	Risperidone or olanzapine shown effective as augmentation therapy with SSRIs or SNRIs (Foa 2009)
Monoamine oxidase inhibitors (MAOIs)	Has been shown effective at reducing reexperiencing symptoms but has not been extensively tested (Foa 2009)
Anticonvulsants	Results have been varied and inconclusive
	Cannot be recomm ended for treatment at this time (Foa 2009)
Benzodiazepines	They are contraindicated for PTSD treatment and should not be used (Foa 2009; U.S. Department of Veterans Affairs National Center for PTSD 2010)
	No evidence supporting the effectiveness of preventing or reducing the core symptoms of PTSD (Berger et al. 2009)
	May reduce the effectiveness of CBT (Davis et al. 2006)
	Have historically been frequently prescribed to prevent trauma-related symptoms or to reduce PTSD symptoms (Berger et al. 2009)

Pharmacological Treatment

Clinical guidelines for the treatment of PTSD by the National Institute for Clinical Excellence and the International Society for Traumatic Stress Studies (ISTSS) recommend that PTSD initially be treated with a course of TF-CBT or EMDR. These guidelines do not recommend pharmacological interventions as first-line treatment; however, medications may be indicated for use when there is significant sleep disturbance, when severe and persistent hyperarousal or depression interferes with a person's ability to make gains in treatment, when he or she refuses to engage in therapy, and when therapy alone is not effective at reducing symptoms (Foa 2009; National Institute for Clinical Excellence 2005; U.S. Department of Veterans Affairs National Center for PTSD 2010).

Practice guidelines by the American Psychiatric Association (APA) conclude that pharmacological treatment and exposure-based psychotherapies have equal levels of empirical support (Benedek et al. 2009). Numerous studies as well as practice guidelines from APA and ISTSS indicate that the SSRIs or SNRIs should be used as first-line pharmacological treatment. Risperidone or olanzapine is recommended as augmentation pharmacotherapy when an SSRI alone does not lead to significant symptom relief (Benedek et al. 2009; Berger et al. 2009; Foa 2009; Sullivan and Neria 2009). Benzodiazepines are contraindicated in PTSD based upon some studies—further examination is needed as studies have not distinguished recently traumatized from PTSD. A further summary of current research on classes of medication and recommendations for their use is presented in Table 12.4.

Issues of Race, Culture, and Diversity

Of the great number of articles about the epidemiology and the efficacy of PTSD treatment in the past 2 decades, relatively few have focused on racial and ethnic groups. Triffelman and Pole (2010) argue that this area of research must be greatly expanded to address the growing population of people of color in the United States. One 2010 study (Lester et al. 2010) of CBT treatment outcomes among African-American and White women with PTSD showed earlier drop-out rates among African-American women; however, it showed minimal difference in treatment outcome. The African-American women might have experienced similar outcomes because they overcame social factors deterring them from treatment, and thus might have been more motivated. This study raises the issues of clinician awareness of racial and cultural identity, and speaks to the importance of clinicians using a race lens in practice (Peacock et al. 2011). It should also be noted that issues of race, ethnicity, and culture could affect the course of PTSD. Traumatic events that include perceived racial discrimination, for example, African-American soldiers who reported being given more severe combat duties than Whites, may result in more severe PTSD symptomatology (Pole et al. 2005).

Pole et al. (2008) reports that despite the fact that the four largest racial and ethnic minority groups (African-Americans, Latino Americans, Asian-Pacific Islander Americans, and American Indians) represent nearly 30% of the American population, it is difficult to find information on minority mental health in mainstream psychology journals. In a review of the literature of PTSD trends among minorities, Pole reports that the evidence for elevated rates of PTSD among African-Americans is mixed; that the bulk of the research indicates higher rates of PTSD among Latino Americans; that there have not been enough studies on Asian-Pacific Islanders to conclude information about rates; and that one study of American Indian Vietnam Veterans found that American Indians experienced the highest rates of PTSD among any ethnic group, and nearly double the rates of European Americans (Beals et al 2002).

This cursory review indicates that more research is needed not just about PTSD rates, but also about the effectiveness of treatment. Additionally, social factors based on racial and cultural identity—such as community support, participation in faith communities, and extended family roles—need to be considered as elements that may decrease risk of PTSD and aid in recovery.

Client/Consumer Role

PTSD is a disorder unlike any other. There is a known trigger (the trauma), and at the heart of the disorder is avoidance of talking about what happened. The clinician's role is to guide the patient through treatment, while not forcing forward movement or becoming complicit in avoidance. For this reason, constant psychoeducation about the treatment process and the creation of a safe working environment are crucial. Trauma often causes feelings of powerlessness, since the individual was likely unable to stop the event from happening, either physically or emotionally. Regaining power, or a sense of mastery over the trauma, is a part of recovery. Therefore, it is critical for the patient to feel *in control* in the treatment process. The patient must remain actively engaged and "drive the train" of treatment as the clinician helps to direct it. Clinicians should expect patient avoidance, which can manifest itself in missed sessions, unanswered phone calls, omission of trauma details, and non-completion of assignments between sessions (a common component of CBT-based trauma therapies). The clinician should acknowledge these forms of avoidance through open communication, so the patient can voice his or her fears and concerns in a safe environment.

Implementation Issues

There is a parallel between the symptoms of PTSD and the impact on implementation. Not only do patients experience avoidance as a part of PTSD, but often clinical staff and systems are complicit in avoiding trauma discussion.

On a micro level, clinicians often worry about "re-tzraumatizing" patients by discussing the trauma. The clinician must have the skills to talk about the treatment process with the patient and to provide gradual exposure (TF-CBT Web 2005). On a macro level, research over the past 20 years has greatly changed the face of trauma treatment. With treatment as usual, such as a client-centered approach, the trauma may only be addressed as the client raises it, and due to the nature of avoidance, this will likely be infrequent. Utilization of new methods, such as CBT and EMDR, requires a shift in approach to the work. It takes time for clinics, hospitals, and treatment centers to implement new models and practices, become TISC, and utilize universal screening for trauma (Hodas 2006). This requires training and a different lens to be used each time a new patient enters the service setting. Utilization of new methods may also affect billing and insurance reimbursement. Examples of this include art, drama, and body-centered therapies that may be effective as a primary or supplementary method of treating PTSD. Despite implementation challenges, many clinical environments have successfully shifted services to become trauma-informed.

Self-Care and Secondary Trauma Prevention

As defined by Osofsky et al. (2008), "vicarious traumatization (VT) or compassion fatigue (CF), also labeled secondary trauma, refers to the cumulative effect of working with survivors of traumatic life events…as part of everyday work" (p. 91). Pearlman (1995) refers to vicarious traumatization as "a process of change resulting from empathic engagement with trauma survivors. It can have an impact on the helper's sense of self, world view, spirituality, affect tolerance, interpersonal relationships, and imagery system of memory." Anyone working with trauma survivors is at risk of being affected by secondary trauma. Signs and symptoms can be similar to those of direct traumatization (Osofsky et al. 2008).

Prevention of secondary trauma is imperative for all workers. Self-assessment of exposure to trauma-related material and symptoms of compassion fatigue is an essential first step in preventing and treating vicarious traumatization. On a systems level, agencies should address the risk of secondary traumatization by offering adequate training, providing consistent supervision and support during crises, encouraging open communication among employees, modeling and encouraging self-care, demonstrating explicit appreciation for work with traumatized clients, and providing variance within caseloads.

It is equally essential that clinicians use personal self-care techniques within and outside the workplace. Personal self-care within the workplace should focus on pacing of work, building in time to talk to colleagues and engage in collegial support, utilizing supervision and crisis help, and managing and tolerating the strong affects raised by trauma-focused work. It is also important to build a personal sense of safety and stress management. This can include taking breaks, eating lunch, going for walks, engaging in brief moments of stretching, breathing, or mindfulness, not answering every call immediately, and creating a soothing office environment. Techniques for personal self-care outside the workplace include practicing stress management through meditation, prayer, conscious relaxation, deep breathing, and exercise, obtaining emotional support from others, engaging in hobbies and enjoyed activities, getting adequate sleep, eating regularly, taking vacation, and developing a written plan focused on maintaining work–life balance. It may also be helpful to consider seeking therapy for unresolved trauma given the potential activating effects of engaging in trauma-focused work.

Working with survivors of traumatic event(s) can be extraordinarily rewarding. Trauma work is different than treating other disorders, and it takes tremendous focus and determination. The patient and clinician need to partner in a unique way. As a person becomes master over the trauma, rather than a victim of it, he or she can often enjoy life and function again, which can be overwhelmingly satisfying for the clinician who witnesses this transformation.

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13 Cognitive Behavioral Therapy for Psychosis (CBTp)

Michael Garrett

Introduction

The psychotherapy of psychosis has a long history (Stone 1999). Cognitive behavioral therapy for psychosis (CBTp) did not gather momentum until the late 1980s and early 1990s, when groups of cognitive psychologists in Great Britain and elsewhere began studying the cognitive processes underlying psychosis (Bentall and Kaney 1989). This led to a cognitive model of psychosis (Garety et al. 2001) and treatments based on that model. A number of comprehensive textbooks of CBTp are currently available (Chadwick et al. 1996; Kingdon and Turkington 2005; Beck et al. 2009). To date there have been numerous evidence-based controlled trials of CBTp which testify to the effectiveness of CBTp (Wykes et al. 2008; Tai and Turkington 2009).

What is CBTp? CBTp is a structured form of psychotherapy which combines essential clinical skills used in psychodynamic psychotherapy and cognitive behavioral therapy for non-psychotic conditions with a specialized "tool box" of CBTp techniques. Contrary to the popular belief that delusions are incorrigible fixed beliefs not amenable to change, research indicates that delusions are multidimensional, changing over time in degree of conviction, distress, preoccupation, action, insight, and interference with daily functioning (Brett-Jones et al. 1987). While mistaken in their delusional beliefs, psychotic individuals nevertheless retain the ability to think logically in other mental spheres (Kemp et al. 1997). CBTp seeks to harness this residual logical capacity to help the patient consider alternative beliefs to their delusions. The doctor–patient relationship is radically different in CBTp than the traditional working alliance in psychodynamic treatment. Although psychological in focus, CBTp does not exclude the importance of biological factors in psychosis. CBTp can and should be combined with other forms of treatment, including medication, family therapy, group therapy, and residential living programs. Although CBTp can address a variety of psychotic symptoms, the central targets of CBTp have traditionally been positive symptoms of psychosis, including hallucinations and delusions.

Cognitive Behavioral Therapy for Psychosis

CBTp can be conceived as a sequence of nine steps. Needless to say, this is an outline to conceptualize treatment rather than a cookbook which can be rigidly followed. In the real world

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treatments proceed two steps forward, one back, with essential digressions to attend to concrete needs. Steps of CBTp include:

Engaging the Patient

It is difficult (but not impossible) for two people with fundamentally different views of reality to have a conversation. Many patients become convinced that it is impossible to have a meaningful conversation with a mental health provider because they expect the mental health system to dismiss their most meaningful experiences as "crazy." Despite the difficulty of communicating about delusional experiences, many patients yearn to have an earnest, good faith conversation about what is important to them, and can do so if properly approached. CBTp provides the means to do this. In contrast with the traditional reserved, "neutral" stance of the psychodynamic therapist, the CBTp clinician aims to be relaxed, open, familiar, chatty, and transparent rather than remote, impersonal, and seemingly all knowing. In the first session the therapist should inquire as to the patient's understanding of the purpose of the meeting. The therapist should make an effort to elicit any specific anxieties the patient may have about the meeting, and to address them. Some delusional patients believe they are putting their lives at risk by talking with the therapist. From time to time, the therapist should take stock, asking "How are we doing so far?"

Conceptual Models Which Guide CBTp

Three conceptual models guide CBTp. Gradually introducing the patient to these three models can help establish the therapeutic alliance. These three models are:

1. The continuum model
2. The stress/vulnerability model
3. The A-B-C model

The Continuum Model assumes that psychotic experience is not categorically distinct from ordinary mental life, but that psychosis lies at one end of a continuum with everyday experience. A continuum of beliefs exists in the general population from near universal beliefs to unusual idiosyncratic ideas to frank delusions. For example, a substantial portion of the general public not otherwise considered mentally ill believes in thought transference, ghosts, voodoo, and the reality of the Devil (Kingdon and Turkington 1994). A continuum of perceptions exists as well. Within the first year of bereavement, half of grieving spouses felt the presence of the deceased spouse and about one third reported seeing, hearing, and talking to the deceased (Grimby 1993). Five percent of the general public not otherwise diagnosed as mentally ill hear voices (van Os et al. 2000). While most people consider themselves to be logical, and the mentally ill irrational, in fact there are deep veins of irrational thinking in ordinary mental life (Sutherland 1992). For example, when confronted with evidence contradictory to their beliefs, 23% of ordinary subjects felt more convinced rather than less convinced of the correctness of their belief (Lord et al. 1979).

The continuum translates to CBTp technique in the concept of "normalizing" psychotic symptoms. Rather than categorize the patient's symptoms as indicative of an illness which sets them apart from the larger community, the CBTp therapist suggests to the patient there are analogies to psychotic experiences in everyday mental life which constitute a continuum between the patient and everyday thinking, including what goes on in the therapist's mind (Garrett et al. 2006; Garrett 2010). In this context the CBTp therapist is encouraged to make statements of cautious, focused self-disclosure to the patient. For example, the therapist might reveal he sometimes hears someone calling his name when no one is present, linking this hallucination of everyday life to the patient's voice-hearing experiences. "Normalizing" psychosis and self-disclosure sharply contrast with the traditional neutral stance in psychodynamic therapy. "Normalizing" psychotic symptoms reduces the stigma of mental illness by placing the therapeutic relationship on a more equal footing. A strict biomedical approach implies, "You have schizophrenia and I don't." The CBTp therapist wants to suggest, "We all have a bit of what you have."

The Stress Vulnerability Model is an open model which maintains that psychosis results from a

3×3 interaction of multiple elements, in which a biological, psychological, or social stressor interacts with a biological, psychological, or social vulnerability, leading to psychosis (Zubin and Spring 1977). At one extreme, a person with a high genetic vulnerability might become ill in response to the stresses of ordinary life. At the other extreme, a person with no biological vulnerability might become ill in response to a traumatic stress, like combat, bullying, or physical or sexual abuse, or the social stressors of immigration and poverty (Read and Ross 2003). Illustrating the interaction between genes and environment, adoptees with a high genetic vulnerability to psychosis had a 1.5% incidence of schizophrenia when raised in a healthy family environment and a 13% incidence of schizophrenia when raised in a disturbed family environment (Tienari et al. 2004). The stress/vulnerability model can be understood by most patients. It helps patients think about the interaction between their mental life and external events.

The A-B-C Model is the third model used in CBTp (Chadwick et al. 1996). With practice, most patients can grasp this model and apply it. The "A" is an activating event, which might be an internal event like hearing a "voice" or an external event in the person's life, or a seeming external perception linked to an idea of reference. The "B" is a belief about the personal meaning of that event. The "C" is the emotional or behavioral consequence of this belief. The CBTp therapist attempts to show the psychotic patient that his distress about the activating event "A" results not from the event per se, but is mediated by his beliefs about the meaning and personal significance of the event. For example, a patient who hears a "voice" saying "Take care!" ("A") might find the voice more or less distressing depending upon whether he believes the voice is expressing a threat or a concern ("B"). For many psychotic patients the "A" and "B" are fused. The psychotic person does not consider alternative explanations for "A." The therapist aims to separate the "A" and the "B" and subject the patients' beliefs to scrutiny. "If your beliefs about the meaning of your experiences are correct, your distress is understandable. If there is another explanation it is in your self-interest to examine your beliefs and alternate explanations closely to see if there is any other point of view." The therapist joins with the patient as a research collaborator gathering data and examining alternative hypotheses to explain the patient's experiences. In psychoanalytic terms, CBTp offers a carefully orchestrated progression of steps and a special toolbox of techniques which provides a massive reinforcement of the psychotic patient's observing ego.

Eliciting the Patient's Story: Timeline and Initial Assessment

Having established initial rapport with the patient, the therapist should encourage the patient to describe what he or she thinks is happening, and why. Where and when does the patient believe his/her story begins? When eliciting the story, it is important to elicit what evidence the patient has for his/her belief about what is going on. Sometimes the psychosis can be traced back to a single seminal event which has left a deep impression on the patient, determining the patient's beliefs. Sometimes the patient may report a sequence of experiences which gradually over time build conviction in his/her beliefs. For example, patients who repeatedly experience ideas of reference may reason, "If I saw this happening once or twice, I might be able to disregard it, but I see it everywhere, over and over again! I see it too often to doubt it." At times the patient's actions bring about a social reality which confirms his beliefs. Whether from acute, life transforming events, slow accumulation of evidence, or confirming reality, it is important for the CBTp therapist to know not only what the patient believes, but what evidence the patient holds in support of his/her beliefs, so this evidence can be challenged later in treatment.

It is essential to elicit what the patient finds most distressing about his/her current situation. The central aim of CBTp is to identify sources of distress and to form a therapeutic alliance based on a collaborative effort to diminish this distress. This allows the patient and therapist to develop patient-centered goals endorsed by the patient

rather than treatment goals imposed upon the patient from outside. For example, a patient who hears the voice of God telling him he is the Messiah may welcome the "voice" rather than find it distressing. However, the patient may find it distressing that his mother brings him to the hospital whenever he talks about being the Messiah. From the patient's point of view the problem here is not the "voice" per se, but his family's response to the "voice's" announcement.

The therapist should expand the patient's initial account of what is happening into a more extended history. It can be useful to note this history on a piece of paper (legal size, or even ledger size) along a horizontal time line drawn on the paper. Drawing the line and locating events along it grounds the patient's history in a visual linear time sequence. This helps stabilize the content of the history in a manner that may facilitate the patient and therapist making connections between events in the stress/vulnerability model. The therapist may point to a note on the time line saying, "You told me you and your family were under a lot of stress when you first moved to this country. It appears you first became concerned that the FBI was tracking you shortly after you arrived here." Working from the paper timeline sets the stage for the patient working on paper homework assignments, such as diaries of various types, and homework reading assignments. As would be the case in any careful assessment, the therapist should inquire if there is any history of physical or sexual abuse, or bullying in school, as these have been correlated with psychosis. Substance abuse is another important contingency.

For patients who hear "voices," the voice-hearing experience is often a complex and compelling aspect of their emotional life (Nayani and David 1996; Leudar et al. 1997). The CBTp therapist needs to go beyond ascertaining the mere presence of "voices," to explore the voice-hearing experience in detail. A thorough assessment will include inquiring about the identity of the "voice," the perceived purpose of the "voice's" communication, the perceived power relationship between the patient and the "voice" (which almost invariably gives the "voice" the upper hand), the patient's beliefs about the consequences of noncompliance with the voice's instructions, and an assessment of whether the patient regards the "voice" as omniscient and omnipotent. Consider an example. A 17-year-old reported he heard a female voice repeating what he was thinking out loud right after he finished thinking a thought. He concluded that the "voice's" ability to repeat his thoughts immediately and accurately was proof she could read his mind, and was therefore omniscient. From a psychological perspective, the voice echoing his thoughts is a pathological form of self-awareness. Given his anomalous subjective experience, his conclusion that the voice can read his mind is quasi-logical. Delusions are often quasi-logical explanations of anomalous perceptual experiences (Maher 1988). The therapist should aim at a sufficiently detailed understanding of the inception of delusional beliefs to be able to articulate, from the patient's point of view, how the delusion appears to make sense.

The Therapist's Formulation

Having established a treatment alliance, taken an initial history, and performed a preliminary clinical assessment, the CBTp therapist should attempt an initial formulation of the patient's psychosis. A formulation is a hypothesis about the origins and antecedents of the psychosis. In general, psychotic individuals believe that conditions in the outside world are responsible for their distress rather than internal mental events, e.g., a "voice" outside the self is haranguing the patient, the CIA is following the patient, a neighbor has planted a chip in the patient's brain, and so on. The aim of CBTp is to examine the patient's beliefs which cause distress, and to gently raise doubts about the patient's delusional formulation, to encourage an alternate explanation which is less distressing and more adaptive. Formulations range from simple to complex, and may evolve over the course of treatment.

Based on the history the therapist will identify factors which predispose to psychosis, which might include a history of mental illness in the family, a history of physical or sexual abuse, or bullying, immigration, and poverty. Precipitants

of the psychosis may include acute traumatic events such as the loss of an important relationship, a death, divorce, being a victim of violence, the inability to negotiate an ordinary developmental hurdle such as leaving home, comorbid medical problems, or substance abuse. Factors which might perpetuate the psychosis would include a high negative expressed emotion, family environment, absence of family support, social isolation, homelessness, lack of work, substance abuse, and prior unsatisfactory interactions with mental health providers and/or clinical features which lead to non-adherence to treatment. Protective factors which might mitigate the effects of the psychosis might include good family support, economic stability, intelligence, and insight. It may be possible to identify a "trigger" often associated with the psychotic symptom, such an external time, place, or occasion when the symptom might likely appear, e.g., when alone or in a stressful interpersonal interaction.

For example, consider a woman who heard voices predicting a variety of people were going to die. Her mother died and she divorced and became a single mother in the same year, preceding her first psychotic episode. The psychosis was perpetuated by her social isolation, and prior bad experiences with the mental health establishment which led her to avoid contact with psychiatrists. Protective factors included adequate family supports, both interpersonal and financial. One of her daughters convinced her to have a consultation for CBTp with the psychiatrist's agreement prior to the initial meeting that the psychiatrist would not insist on the patient taking medication. The voices tended to be triggered by loneliness, when her attention was not otherwise occupied. In the A-B-C model, the "voice" is the activating event. The patient believed the "voices" were omniscient and omnipotent. Her evidence for this belief was the fact that the "voices" accurately predicted Frank Sinatra's death. She believed a government agency issuing coded license plates maintained powerful computers which the "voices" used to gather information for their predictions. The "C" consequences of this belief included feelings of anxiety, anger, and fear relating to the "voices," thoughts that she was responsible for warning people who were going to die, and the behavioral consequence that she remained at home absorbed for hours trying to figure out what the voices were hinting at. After CBTp lasting 4 months of weekly 45 min sessions the patient understood the voices were a manifestation of her own thoughts. The voices decreased in intensity by 50% and she no longer feared them. For a complete summary of the use of the formulation in this patient's treatment see Garrett (2010); see Garrett and Turkington (2011) for a more complete discussion of the relationship between psychodynamic formulations and CBTp.

Introduce Treatment: Initially Focus on Coping Strategies

The therapist should advance CBTp by focusing on what the patient finds stressful, the "C" in the A-B-C sequence. Before challenging beliefs, it is useful to focus on how the patient has so far coped with the experiences that distress him. Focus on coping mechanisms underscores whatever strengths the patient may have in facing symptoms and situations. Reminding patients they have some ability to cope emphasizes the patient is not completely helpless in the face of the outside dangers he fears. The therapist may be able to suggest ways the patient's coping techniques could be more effective, or to suggest new techniques the patient has not tried.

Introduce the A-B-C Model

Having explored coping techniques, the therapist can introduce the A-B-C model. It is useful to sketch the A-B-C sequence on paper while discussing it, and to "normalize" the model as a way of viewing ordinary cognitive processes as well as disturbances of thinking. The therapist might say, "Events occur throughout the day which have different meanings for us. In our A-B-C model, an event that happens is the 'A'. Our belief about the meaning of the event is 'B'. And 'C' is the consequence of our belief, how we feel and what we do as a result of our belief."

The therapist can take the lead by offering an example from personal experience. For example, a psychiatrist-in-training offered the following personal vignette while introducing the A-B-C model to a patient. "There used to be signs in the library that you were not allowed to take food there but you could have water in a spill proof container. Yesterday that sign wasn't there. I was sitting at a desk and the librarian was walking toward me. I had my spill proof water bottle out on the table. I thought she was going to tell me I couldn't have it, and I was getting ready to argue with her that a spill proof container was allowed. It turned out she just walked by. I jumped to the conclusion she was thinking about me, but it wasn't about me." The therapist used this example to illustrate the A-B-C model, where "A" is the librarian walking toward him; "B" is his belief the librarian intends to prohibit the water; "C" is irritation and mild anxiety. The therapist identified a "jumping to conclusions" bias as well as an "over personalizing" bias in his own thinking, two of the most common cognitive biases operative in psychosis.

Having illustrated the model with a personal vignette, the therapist can use the A-B-C model to analyze a relatively neutral event in the patient's life. This gives patient and therapist practice using the A-B-C model. As the therapist starts to apply the A-B-C model to the patient's core psychotic experiences, the therapist might "normalize" symptoms by describing personal examples of cognitive bias, or brief hallucinations of everyday life experienced by the therapist.

Investigate Beliefs

Having built the therapeutic alliance, "normalized," and practiced the A-B-C model, the therapist should encourage the patient to examine core psychotic experiences. It is useful to sketch two columns on a piece of paper, to examine alternative theories. As illustrated in Table 13.1, at the top of the paper, list the "A" being examined. An "A" may be a mental event, like a "voice" or a perception linked to an idea of reference, or an event in the external world. In the left hand column list the patient's belief, along with the evidence the patient has for the belief. It is useful to keep sessions structured, beginning with a summary of the previous session, proceeding to homework, and the work of the current session, new homework assignment, and concluding with a summary of the current session.

Table 13.1 "ABC" notations

Activating event "A" What precisely did the patient experience?	
Patient's current belief	Alternate explanations
List evidence patient offers for current belief	List evidence for alternate explanations
Examine the evidence for current belief	Examine evidence for alternate beliefs

It cannot be emphasized enough that the therapist must clarify the nature of the "A" as precisely as possible. What exactly did the patient experience? What precisely did the patient see or hear? The patient may have actually experienced only a vague, muffled sound, but this "A" may be quickly elaborated into a delusional belief. Like a surgeon dissecting critical anatomical structures, the therapist must separate the "A" from the patient's belief about the "A." For example, a patient reported that he overheard two girls talking about an embarrassing video of him he believed had been posted on the internet. When asked what precisely had he heard (the "A") he said one girl said, "He will never find it." When the therapist asked if there had been a direct reference to him or the video he acknowledged there had not. Nor had he actually spoken to anyone directly who had seen the video. It now became possible to point out to the patient his report that the girl was talking about him was a belief rather than a fact.

Patient and therapist can rate the degree of conviction in B on a scale from 1 to 100. Even a 1% degree of doubt offers the possibility of investigation. The therapist might ask, "Do you have the same degree of conviction at all times, or has it changed from time to time?" Changes in conviction may allow the therapist to point out that unlike facts, beliefs can change. The therapist shapes the alliance as the collaborative research of two investigators, seeking and weighing evidence, considering alternative hypotheses. It can be

useful to ask the patient, "As we consider various alternatives, which would you prefer to be true in the end when we have finished investigating?" The patient's response can be telling. Some patients say they would prefer their belief not be true. Other patients say they would prefer their delusion to be true, because otherwise, "I am crazy." Some people would prefer to suffer the anxieties related to a paranoid delusion rather than surrender to society's label of being "crazy." Like all investigators, patient and therapist have a "tool box" of research methods and specific techniques at their disposal. These include the following:

1. Identify triggers or settings in which "A" tends to occur. When does "A" not to occur?
2. Can the patient do anything that increases or decreases the symptom? Control implies empowerment, and places the causal locus within the self.
3. Agree to disagree about alternate explanations. Avoid a vote. "Let's see how it turns out in the end."
4. Peripheral questioning. "Let's go into the details of what actually happened."
5. Rate the likelihood of beliefs.
6. Rate the value of particular evidence for or against a belief.
7. Provide informational handouts to increase real world knowledge.
8. Inference chaining. "If that turned out to be true, what would that mean to you?"
9. Reality testing experiments. These must be carefully designed so as to yield unambiguous results.
10. Homework assignments, e.g., voice-hearing diaries.
11. Examine beliefs about noncompliance with "voices." Identify situations in which the "voices" appeared weak, unable to carry out their threats.

Reformulate the Patient's Story, and Challenge Beliefs

Having examined the patient's core beliefs in the A-B-C format, the therapist may gently encourage consideration of alternative views. Again "normalizing" the patient's symptoms, the therapist can offer an enriched stress/vulnerability, cognitive, or bio/psycho/social formulation, which can play a more adaptive role in the patient's recovery. "You were under stress when you saw/heard A, which led you to believe B. You had good reasons for believing B at the time, but we can now see that there are alternate explanations of A." The therapist can now offer a new formulation which has gradually been taking shape over the course of the investigation.

A stress/vulnerability reformulation might take the form: "Your mother's death was very stressful for you. You weren't sleeping well, and were using drugs to ease the pain. In that totally stressed out state you had some disturbing experiences, like thinking the neighbor was trying to poison you. We can now see that those experiences and beliefs were the result of the upset state of mind you were in at the time." A cognitive bias reformulation might emphasize cognitive errors. "Like all of us, you have a cognitive bias where you tend to jump to the conclusion that people are paying special attention to you. You tend to personalize events, believing people are referring to you when they are not, and you often think strangers want to hurt you, even though there is no evidence for this." A bio/psycho/social reformulation might proceed: "You felt if you had set a better example for your brother, he might not have died so young. You felt guilty, and when you couldn't get your life going after you came back from the Navy, you felt ashamed. You criticized yourself. Over the years those feelings of guilt and shame built up, and you came to feel that shame everywhere you went, including those times you thought dogs in the neighborhood were looking at you and mocking you."

If CBTp successfully challenges the patient's delusional beliefs in favor of more adaptive alternatives, the patient's recovery shifts to firmer ground. A successful course of CBTp is only the first phase of psychotherapy for psychosis, and only one among many treatment approaches of use to patients, including family therapy, pharmacotherapy, social skills training, group programs, and assisted living residences.

Maintenance and "Booster Sessions"

All chronically psychotic individuals benefit from long-term follow-up with a therapist who has earned the patient's trust. Once the patient has come to understand that events once believed to be occurring in the outside world actually represent changes of mind, patient and therapist can develop a list of early warning signs of relapse. These signs may include nonspecific anxiety, depression, or insomnia, or the return of specific beliefs and fears which once characterized the psychosis. Over the course of CBTp patients learn to examine their thoughts. The acronym "Catch It. Check It. Change It." is easily taught and readily applied by many patients. The patient learns to "catch" biased cognitions, "check" them by weighing evidence for and against, consistent with prior CBTp work, leading to a "change" in the thought. Some patients can apply understandings gained in a prior course of CBTp to a new episode of psychosis without much help from the therapist. Most patients in ongoing treatment can use the therapeutic relationship and past CBTp work to examine new symptoms as they emerge, quieting what might otherwise have progressed to a full psychotic decompensation and readmission.

Long-Term Follow-Up and Self-Building

Even if CBTp is successful in undermining delusional beliefs, psychotherapy cannot be considered complete. Most people with a history of chronic psychosis benefit from a long-term therapeutic contact with a clinician who can help the patient clarify what he is thinking and feeling, and to serve as a sounding board for ideas and decisions (Lotterman 1996; Lysaker and Lysaker 2008).

Implementation

There are numerous obstacles to implementing a CBTp treatment program, some having to do with the need for specific clinician training, some with service delivery design and coordination, and some with the competing priorities of different interest groups which compose mental health systems. An ideal service delivery design would have the CBTp therapist meet the patient shortly before discharge from the hospital, bridging a connection to an outpatient day program or outpatient clinic where CBTp could occur. Like any psychotherapy, CBTp requires time. In a 15-min appointment there is no time for any psychotherapeutic ambition.

When the clinician takes the time to explore the patient's experiences in CBTp mode, the patient emerges more fully as a person. For example, a psychiatrist resident-in-training who had been seeing a patient for brief "med checks" for almost a year took the time to inquire in detail about the patient's voice-hearing experiences. With this prompting the patient revealed for the first time a dimension of his daily life of great concern to the patient. The patient reported a "voice" constantly urging him to prepare large quantities of fried chicken. The patient was unable to ignore the "voice." He spent so much of his modest monthly budget on fried chicken he often came up short by the end of the month. Discussion of this issue literally invited the doctor into the patient's home for the first time, and ushered in a new phase in their relationship marked by humor and attention to quality of life issues. In the course of CBTp the patient was able to diminish the power of the voice and take control of his diet and budget.

In conclusion, it is hoped this chapter provides enough information about CBTp for clinicians to decide whether this treatment fits with their approach to patients and to seek additional training if interested.

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14 Integrated Care and Psychiatrists

David A. Pollack, Lori E. Raney, and Erik R. Vanderlip

Introduction

The world of health care in the United States is changing fairly rapidly, especially with regard to how care is delivered. Providers, patients, and payers need to adapt to the changing healthcare environment to maximize their effectiveness and to avoid being made irrelevant by this cataclysm of system transformation, particularly the specialized interface between primary care (PC) and behavioral health (BH) (which includes mental health and substance use disorders and the patients/services/providers associated with such conditions). It is abundantly clear that delivery system redesign is essential to improve health of the population, improve patient experiences with the delivery of healthcare services, and reduce per capita costs for such services.

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The prevalence and burden of mental health conditions, their frequent comorbidity and confounding interdependent relationships with other health conditions and treatments, and the need for coordination of care for persons with such complex and multifactorial presentations are key components of the BH–PC interface. It is important to emphasize that psychiatrists are critical to this interface because of their bio-psycho-social expertise, their chronic illness management focus, their understanding of and utility in modifying human behavior, and their leadership skills. We mention these clinical and leadership functions, not to establish or preserve psychiatric hegemony over the provision of mental health and addiction services, but to objectively assert the unique strengths of well-prepared psychiatrists that make them essential to the BH–PC interface.

Policy experts have repeatedly and consistently cited the lack of sufficient numbers of providers and inadequate organization of services in PC settings as key contributory factors in this system inadequacy. Beyond expanding the number of PC providers and improving services with the intention of expanding the PC safety net, the relationship of BH and PC on an interpersonal and systems-based level must be considered. This chapter is intended to address the ways that psychiatrists should be trained, organized, oriented, utilized, deployed, supported, and monitored in integrated systems of care. The range of roles in which psychiatrists can engage include team-based direct clinical assessment and care,

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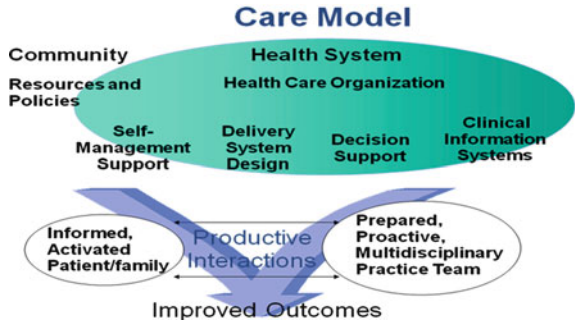

Fig. 14.1 Chronic Care Model

consultation with a wide range of providers, training, policy development, quality improvement, research and evaluation, system implementation, and leadership within such teams or broader systems of care.

It is our intent to be succinct and user-friendly in our presentation of facts and guidance. Since this handbook is intended to guide community and public psychiatrists in aspects of practice that will enhance their effectiveness, we focus on the knowledge and skills needed to function in such systems. We do provide sufficient references to support the factors that contribute to increased effectiveness and improved patient outcomes derived from such practice.

Background

Psychiatrists have been working in PC settings and in collaboration with PC providers for many years. Early models of collaborative care (Morrill 1978) showed the benefit of placing BH providers in PC clinics. Although these approaches failed to achieve broad or systematic acceptance, over the next 2 decades a diverse range of healthcare organizations, including Kaiser Permanente, Group Health of Puget Sound, Intermountain Health, the Veteran's Administration, the Indian Health Service, and Federally Qualified Health Centers (FQHCs), began to develop and implement colocation of mental health services as part of overall health services, allowing closer linkages to PC.

The trend towards integration was facilitated by the introduction of the Chronic Care Model for disease management (Wagner et al. 2001). This model (Fig. 14.1) described the essential elements of an effective clinical organization engaged in meeting the needs of persons with chronic health problems, recognizing that the majority of healthcare costs are associated with chronic health conditions. The six components of this model (Delivery System Design, Decision Support, Clinical Information Systems, Healthcare Organization, Patient Self-management and Support, and Community Resources) were intended to apply to general medical conditions. However, it readily became apparent that they also applied to BH conditions. This realization of the importance of colocation and integration of key clinical disciplines in the delivery of such care quickly followed (Mauer et al. 2005).

Clinical research models were introduced to improve the detection and treatment of depression in elderly patients in PC settings. One of these, the IMPACT (Improving Mood: Providing Access to Collaborative Treatment) study (Unützer et al. 2002), increased detection of depression, improved outcomes, was cost-effective and outperformed "treatment as usual." Over time, IMPACT has become a widely used model for treating mental illness in collaborative care settings. It has been modified to serve diverse age and cultural cohorts and for the treatment of a variety of psychiatric conditions, especially those likely to be encountered in PC settings.

Demonstration projects began testing the components and limits of integrated models across many settings. Several studies showed impressive results and meta-analyses of these

studies identify key factors associated with improved outcomes: (1) primary care providers (PCPs) who are competent and willing to prescribe psychotropic medications, (2) a multidisciplinary team approach that includes point responsibility for care coordination, whether by a BH provider or nurse, and (3) colocated BH providers, including access to consultant psychiatrists (Butler et al. 2008; Bartels et al. 2004; Gilbody et al. 2006).

In the past decade, startling new data emerged showing marked differences in the mortality rates of persons with serious mental illnesses (SMI) as compared with the general population (Parks et al. 2006). Multiple reports called for new models of care to reverse this trend, endorsing the need for specific attention to the comorbid health risks of persons with SMI, including metabolic side effects of psychotropic medications, diet, and other social determinants of health particular to this population (Bazelon Center for Mental Health Law 2004). SAMHSA and other funding organizations have developed initiatives to promote the implementation of "reverse colocation" models, in which PC providers are incorporated into BH specialty programs, especially community-based mental health facilities.

Many of these developments parallel the recommendations from the Institute of Medicine's pivotal series of reports on improving the quality of health care in the twenty-first century (Crossing the Quality Chasm). The IOM stated that an improved healthcare system must be *patient-centered, safe, timely, effective, efficient, and equitable* and that most health providers must be trained to be competent in *patient-centered care, evidence-based practice, and use of informatics, quality improvement methods, and multidisciplinary teamwork*. The IOM even focused specifically on improving the quality of care for mental health and substance use disorders, placing special emphasis on increasing collaboration and integration between BH and PC providers.

In the past 2 decades, but especially in the context of the state and federal health reform initiatives since 2008, the concept of the patient-centered medical home (PCMH, aka integrated health home or primary care home) has taken root. This has led to the development of many different models of care, most of which reflect an emphasis on delivery system attributes such as *access to care, accountability, comprehensive whole person care, continuity, coordination and integration, and person- and family-centered care*. In virtually all the PCMH models and initiatives, it is broadly accepted that services and providers for mental health and addiction are among the most important components and interprofessional relationships. Therefore, we need to think about integration of BH and PC generally, but also in the context of emerging PCMH models.

Basic Concepts of Integrated Care

Terminology

The interface between BH and PC is the metaphorical context within which interactions regarding patients and services may occur. The IOM describes an evolutionary path of the interface moving from one characterized by cooperation through collaboration and eventually to integration. "Integrated care" and "collaborative care" are used interchangeably when discussing this system of care.

The Four Quadrant Model

Integrated care models have changed as they have been implemented and tested in relation to *types of clinical settings, types of BH and general medical conditions, level of risk, acuity, and severity of respective conditions, and the degree of comorbidity or complexity.* The Four Quadrant Clinical Integration Model (Mauer 2006) is a useful conceptual tool (Fig. 14.2) that allows clinical organizations to develop and implement integrated or collaborative care systems by organizing relevant

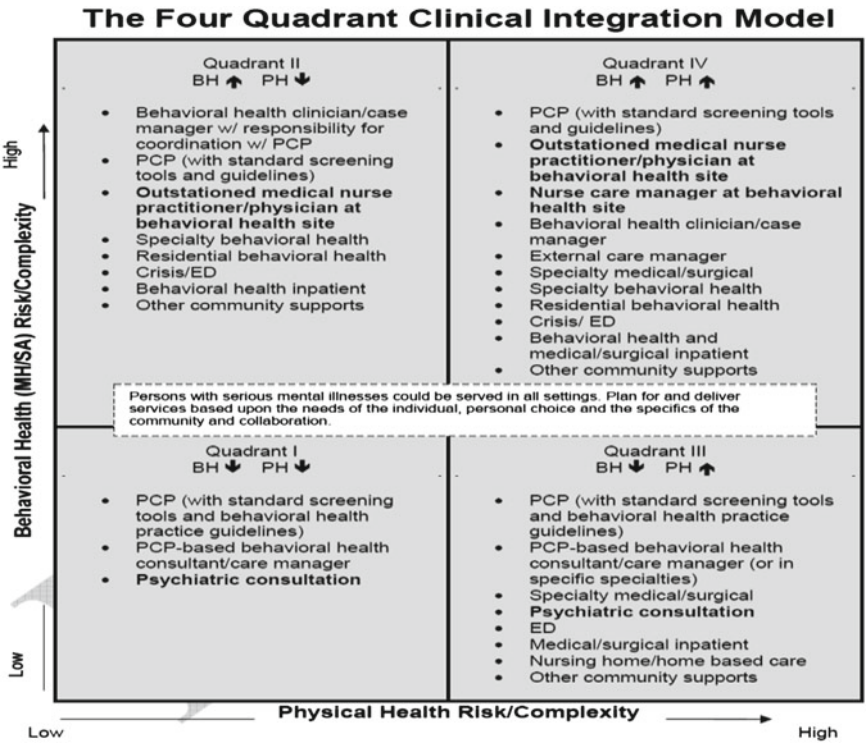

Fig. 14.2 The Four Quadrant Clinical Integration Model

services and staffing in relation to four general population groups based on the parameters described above.

A relatively simple way of orienting to this model is to consider that most persons with severe and persistent mental disorders or substance dependence would fit into the upper two quadrants and that most persons with chronic or more severe physical health conditions (e.g., diabetes, hypertension, heart disease, cancers) would fit into the two quadrants on the right side of the chart. The kinds of BH services, staffing, and resources listed in each quadrant serve as a guide for specific operational delivery system development, but this must be customized in relation to the context in which the clinical organization exists, especially in consideration of *community service capacity; workforce availability, competence, and training potential; organizational support from clinical and administrative leadership; reimbursement factors; cultural characteristics; and patient preferences.*

Levels of Collaboration

It is also useful to codify the degree of collaboration and colocation of providers associated with different models of care. Different models may be more apt for services associated with specific target populations or relevant quadrants in the Four Quadrant Model. They may also be considered as steps along a path to developing a more fully integrated system, one that evolves or develops in relation to a rational and feasible timeframe for system transformation. Ranging from separate site referral based care, to colocation, and varying degrees of clinical integration, this continuum allows planners and participants in the system to compare the elements of their program to a range of options and identify levels of collaboration that are appropriate for their current and future goals. The Levels of Collaboration most often used include:

Minimal Collaboration: BH and PC providers work in separate facilities, have separate systems,

and communicate intermittently as needed for referral purposes.

Basic Collaboration at a Distance: BH and PC providers have separate systems at separate sites and engage in periodic communication about shared patients. Improved coordination is the primary improvement compared to Minimal Collaboration.

Collaboration On-Site with Minimal Integration: BH and PC providers have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in the separate clinical culture.

Close Collaboration On-Site in a Partly Integrated System: BH and PC providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication. There is a greater sense of being part of a clinical team in which providers have separate/specialized as well as shared roles in working together to treat their patients.

Close Collaboration Approaching a Fully Integrated System: BH and PC providers are part of the same team. The patient experiences the BH and PC treatment as jointly and interdependently provided.

A comprehensive 2010 report (Collins et al. 2010) provides clear descriptions of the eight most commonly observed models of care in the United States, identifying the level of collaboration, the relevant or target populations (i.e., quadrants), the current evidence base, as well as implementation and financial considerations for each model.

Stepped Care

In order to manage the limited resources available to provide reasonably effective care, it is important to prioritize and match patient need with the appropriate level of care. This involves developing systematic methods to identify specific conditions and patient needs/preferences, initiate care that is correlated with the level of need, and then adjust the type and volume of care to match the clinical conditions as they change. Stepped care is a care allocation method based on the premises that care should be *least disruptive to the patient; the least extensive, intensive, and expensive care needed for positive results; and least expensive in terms of staff training required to provide effective care*.

Care Models and Psychiatric Roles

The remainder of this chapter focuses on how psychiatrists can function within these clinical care models. As stated earlier, there are numerous models of care involving the integration of BH and PC. There are a very few fully integrated programs that address the PC and BH needs of the whole continuum of persons with BH conditions. This is an evolutionary goal and may not be fully achieved on a broad basis for many years. The continued existence of mirror image models (BH integrated into PC settings and PC integrated into BH settings) is inevitable and may be preferable in some communities and for some patient populations. Therefore, we address integration and psychiatric roles from these bidirectional perspectives.

Behavioral Health in Primary Care Settings

Effective BH care in PC settings requires a range of functions and staff to perform them. This section outlines the key functions, with reference to the pathways of care, and the functions that are most appropriate for participating psychiatrists. The process of care is more consistent and reliable if a stepped care approach is implemented. Therefore, depending on the level of apparent acuity, severity, and complexity, any of several steps of care may be appropriate, including (1) Provision of basic illness education and self-management referral and information, (2) Direct provision of psycho-educational and motivational support by a clinical team member, (3) Colocated BH provider assessment and/or

brief treatment, and (4) Referral to higher level BH specialist (including psychiatrist) or external BH services. The specific staff suited for any of the above steps will vary depending on clinical conditions of patients, composition of the multidisciplinary team, and number, type, and FTE of BH staff who are colocated or integrated with the team.

The fully integrated team will be composed of some combination of traditional primary care team staff, including PC providers (physicians and/or other prescribing providers, such as nurse practitioners or physician assistants), nursing staff, medical assistants, reception and other support staff, and BH clinical staff. The BH clinical staff must include non-prescribing BH specialists (e.g., social workers, licensed counselors, psychologists), prescribing psychiatric providers (psychiatrists, nurse practitioners), and possibly nonprofessional BH staff to handle certain patient education, motivation, or care management functions. The step at which patients enter into the process will also vary depending on how clear the diagnostic impressions are at the point of triage/assessment, the level of engagement of the patient, the level of comfort and competence of the non-BH clinical staff, and the negotiated roles for the BH staff.

The pathways and processes of care will involve some or all of the following functions and services: screening; assessment by the PC provider; warm hand-off to BH provider; triage and/or comprehensive assessment by BH provider; case consultation; patient education and motivation support; office-based counseling by PCPs; brief on-site treatment by BH providers, including shared or simultaneous care by PCP and BH providers; referral to external BH specialty providers; care coordination; and outcome assessment. The selection and utilization of screening tools, especially in identifying the conditions for which treatment might be provided, is frequently a key decision support function in integrated programs. These screening instruments (e.g., PHQ-9, GAD 7, SBIRT) can be used with some or all patients in the PC setting to identify persons who may have target conditions such as depression, anxiety, somatoform disorders, and substance abuse. For those patients whose results indicate significant risk or probability of a BH condition, a higher level of assessment is provided, either by the PCP or a colocated BH provider.

If a PCP feels the need for additional diagnostic or treatment support, a referral to a BH provider may be made. Preferably this would involve a "warm hand-off" to the BH provider at the time of the PCP's visit with the patient, depending on the availability of the BH provider. The opportunity to introduce the patient to the BH provider, if only to set a time for a future appointment, increases the probability that continuity of the care relationship will be preserved, just as referral to a BH provider within the PC setting is more likely to be successfully completed as opposed to an external referral to a BH specialty program. The BH provider's assessment may include recommendations for brief interventions and self-care management. PCPs may proceed directly to office-based counseling and/or psychotropic medication treatment, with some of these interventions being provided exclusively by the PCP or by others on the team.

For more complex and challenging patients, the team (PCP, BH provider, or care coordinator) may request consultation regarding diagnostic impressions, treatment recommendations (including medications), and behavioral management concerns. This is most commonly where the integrated team psychiatrist becomes involved. In particular, psychiatrists are most likely to perform assessments of the more complex patients; curbside consultations with PCPs; more complex case-specific consultations derived from direct patient evaluations or from communications with other clinicians directly involved with the patient; and limited direct treatment with psychotherapeutic and/or psychiatric medication interventions. In addition to clinical care functions, integrated team psychiatrists may perform various team and systems level administrative and service coordination functions. These include participation in team meetings, quality improvement, service planning, coordination, training, research and evaluation, and oversight activities.

Particular emphasis must be placed on effective consultation skills, since in some integrated programs, there may be little support or funding for psychiatrists to provide much, if any, direct

care. Psychiatrists should be familiar with and capable of flexibly and adaptively providing the whole range of mental health consultation types, including patient-centered and consultee-centered clinical consultations as well as program-centered and consultee-centered administrative consultations (Caplan and Caplan 1993). Clinical consultation should be directed to supervise and support other BH clinicians and any of the non-BH team members, especially assisting PCPs with diagnostic clarity, psychopharmacology recommendations, behavioral management strategies, and office-based counseling techniques. Among the program level consultation functions, it is also essential for psychiatrists to participate in the development, implementation, maintenance, and sustainability of effective outcomes measures (including BH as well as general medical relevant measures).

The willingness of administrators and the PC team to accept the participation of psychiatrists in these nondirect care functions may require some time for the BH providers to demonstrate their clinical value to the team. The wide variation in how psychiatrists are allowed to perform such functions in community-based mental health programs reminds us that the most appropriate utilization of the broad range of skills that psychiatrists provide may fail to occur. Such administrative decisions are usually related to resource limitations, the level of enlightenment of administrators, the track record of relationships between administrators and psychiatrists at the specific clinic, and myriad other factors. Psychiatrists who have program or agency medical director experience may be more likely to be seen as acceptable for such functions. It is essential, however, that some minimum level of psychiatrist staffing, as expressed through actual FTE amount, should be explicitly determined in BH-integrated programs and PCMH. It would also seem obvious that, in order for this more inclusive range of psychiatrist activities to be actualized at the level of clinical care, there should also be significant psychiatrist participation at the system level (local, regional, state, and national) with psychiatrist medical director positions in the mental health and/or health authorities of those governmental jurisdictions.

Integrated Psychiatrist Skills and Attitudes: Patient-Centered, Evidence-Based, Recovery-Oriented, Culturally Competent, and Trauma-Informed

Key to all these functions is the need for the psychiatrist to be aware of and willing to provide evidence-based care recommendations as much as possible, including awareness of comorbid general health conditions and co-occurring substance use disorders and the developmental, psychological, and sociocultural issues that are relevant to specific patient cohorts, as defined by age, cognitive abilities, or other clinical factors that impact presenting clinical conditions. The psychiatrist must be committed to true collaboration with other health colleagues, mindful of and competent in the communications processes that support such collaboration, and comfortable with and willing to fit into PC culture. The psychiatrist must model awareness of the key patient-centered skills and attitudes that are associated with effective mental health care, including recovery-oriented service principles, cultural and ethnic diversity competence, and trauma-informed care.

Although it is preferable for psychiatrists to provide as much of these functions in person, alternative synchronous or asynchronous communication methods, e.g., tele-video, internet, or telephone, may be necessary and even preferable in certain circumstances for some or all of the psychiatrist's activities with the integrated care team. Teams will often settle into a preferred mode of communication that allows prompt consultation and response time. PCPs may use one mode of communication while the BHPs utilize different modes in a given clinic. It is important for the psychiatrist to find out what works best and to match it to the respective setting.

Working with PCPs in integrated care settings is likely to be challenging, but should also be rewarding. PCPs are generally aware of the high prevalence of BH conditions that present in their clinical practices and are often very eager to learn from and work with effective collaborating psychiatrists. One of the main challenges for BH providers in integrated settings is to manage the range of clinical activities in a balanced way so

that access to triage and assessment visits are readily available. Any significant delay in access, such as a wait list, can undermine the effectiveness and relevance of having integrated BH providers. At the same time, it is important to prevent PCPs from simply referring any and all patients who have any BH concerns, a circumstance that would overwhelm the limited BH capacity and circumvent the opportunity for PCP staff to gain and maintain their own BH assessment and treatment skills.

Tracking key data (either in the EHR or a separate data tracking system), including rates of referrals for certain conditions and outcomes measures for various BH conditions should be reviewed so that patients with various BH problems are neither being over- or under-referred to the BH providers. Such measures, coupled with stepped care protocols, can assure the most appropriate and efficient use of the BH staff while achieving better clinical outcomes. The utilization of disease registries, individual case feedback, and iterative encounters may offer incentives for many PCPs to improve their practices and hone their BH skills, resulting in improved clinical efficiency and comfort in recognizing, treating, and formally referring for BH treatment. The consulting psychiatrist may play a key role in setting up and reviewing such data systems as well as utilizing the data to advise PCPs or their teams on various aspects of care.

The populations of focus are often quite heterogeneous. In many PC settings, a variety of factors may require the consulting psychiatrist to be prepared to work with a wide range of patients, both in terms of age and types of conditions encountered. This could include adolescent and even some child patients, not to mention the elderly, as well as the full gamut of mental health, developmental, and addictions conditions that can be imagined. This may provoke discomfort and even reluctance to see patients for whom one feels less well prepared to evaluate or discuss in consultation, but it is actually advisable for the psychiatrist to participate in such activities. While readily acknowledging the limitations of knowledge and skills, the consulting psychiatrist may be able to access information and resources that will lead to a reasonable assessment and treatment recommendations. Demonstrating such willingness to go outside the comfort zone (when responsibly done) parallels the kinds of "on the job training" and collaborative learning experiences that many PCPs find to be central to their clinical practice. With appropriate backup, many adult psychiatrists can effectively provide consultation across age groups.

Relationship building and continuity are crucial to effective consultations and they may, over time, lead to reductions in requests for face-to-face evaluations of patients or at least a reduction in the number of inappropriate lower severity referrals. Depending on the model of integration utilized, some arrangements have consulting psychiatrists working primarily with the PCP or BH providers and directly seeing few if any patients (Trivedi et al. 2007). Inherent in such models is the assurance of sufficient consultant time, as well as bidirectional trust and comfort among those involved in the collaboration.

Liability

Although the risk of malpractice litigation in the provision of such consultation is considered by many to be relatively low, liability concerns are common among psychiatrists entering into collaborative or integrated care settings. Detailed discussion of these issues is beyond the scope of this chapter. However, it is essential that liability coverage be provided. The level and type of coverage clearly depends on the situation in relation to the employment or contract status of the personnel involved.

Documentation

The consulting psychiatrist must be judicious but thorough in documenting the clinical assessment, treatment recommendations, and consultation transactions that occur in the course of such work. This is a broad subject, also beyond the scope of this chapter. Suffice it to say that, in addition to the need to provide clear and succinct

recommendations, the level of detail of clinical documentation depends on the type of clinical activity, billing codes used, and the availability and sophistication of electronic health record systems. Many psychiatric consultants have found that providing notes (assessments or briefer consultation notes) that follow an APSO format (Assessment, Plan, Subjective, Objective) as opposed to the traditional SOAP format works very well for their PC colleagues.

Primary Care in Behavioral Health Settings

Persons with the most severe and disabling mental health and addiction disorders have a much greater prevalence of comorbid general medical problems, have much greater mortality than the general population, and too often receive little or no adequate PC services. These persons have more difficulty navigating the complex and fragmented healthcare systems in most communities. They may be treated in discriminatory ways in mainstream health settings. These patients (particularly those in the upper two quadrants of the Four Quadrant Model) often receive most of, if not all, their health care within a BH specialty setting, either because they can't access the general medical system, because they or their BH providers fail to recognize or follow up on apparent medical concerns, or due to the overall fragmentation and chaos that characterizes many publicly funded health systems (Alakeson et al. 2010).

Depending on the availability and degree of evolution of fully integrated programs, it may be necessary to develop colocation of PC services within specialty BH settings. Such "reverse colocation" models are well described elsewhere and involve a variety of arrangements in which PC providers are included in the BH setting. Such arrangements involve a similar range of clinical, infrastructure, and administrative variations as described in the section on BH in PC settings. Such models are less abundant and lag significantly in their aggregate level of development, although recent state and federal initiatives are promoting rapid uptake of this care approach.

General Medical Risk Monitoring in BH Settings

This section outlines ways in which psychiatrists in BH settings can better advocate for and, when appropriate, provide general medical care, disease prevention, and reverse colocation and integrated care. It has become well established that persons with mental illnesses have substantially higher prevalence and mortality from a number of comorbid health conditions, including relatively higher levels of all five modifiable risk factors for cardiovascular disease: hyperlipidemia, hypertension, obesity, diabetes, and tobacco use. Of these risk factors, tobacco use is persistently the most significant in its pervasiveness and health impact (Compton et al. 2006; Lasser et al. 2000). Similarly disturbing findings for persons with SMI apply to Type II diabetes, hypertension, and metabolic syndrome (a constellation of abdominal obesity, elevated blood lipids, impaired glucose tolerance and hypertension) (McEvoy et al. 2005). While many factors may be associated with cause and effect mechanisms of these elevated risk factors, the use of atypical antipsychotics, often necessary for symptom control, may create or accelerate these problems. PCPs and psychiatrists fall well short of recommended screening and monitoring guidelines, and rarely utilize well-established and efficacious smoking cessation strategies for this population.

Given the clinical, economic, and quality of life implications of these severe health disparities, psychiatrists and PCPs must be much more attuned to recommended guidelines for screening and prevention of somatic illness with patients in BH or PC settings.

For patients not routinely receiving effective PC and preventive services, whether in PC clinics or in reverse colocation BH programs, comprehensive guidelines for preventive services exist that are particularly relevant to the SMI population. These recommendations include metabolic screening intervals for antipsychotic medications, laboratory and physical exam values useful in the diagnosis of diabetes, dyslipidemias, obesity, and metabolic syndrome, as well as blood-borne and communicable disease screening (HIV, hepatitis,

syphilis, tuberculosis) and vaccination recommendations. A useful checklist follows to guide recommendations to patients or PCPs or BHPs to assist in completion of screening guidelines for this population.

Psychiatrists may also make use of patient disease registries, quality improvement methods, and electronic medical health records to develop and implement screening and monitoring protocols and to improve communication with PCPs. Improving the recognition, referral, and/or treatment of comorbid health conditions for persons with SMI will result in improved outcomes, reduction of morbidity, and ultimately improved health and recovery. This must be a priority for all current and future community psychiatrists.

Psychiatric Leadership in Integrated Care

The vision we have presented in this chapter requires community psychiatrists who are versatile, flexible, and capable of working with a wide range of patients and providers. They must be familiar with public health psychiatry and other aspects of population health. They should demonstrate the core competencies articulated by the Institute of Medicine, described earlier, as well as the more recently released Core Competencies for Interprofessional Collaborative Practice developed by a consensus group representing the major health disciplines (Interprofessional Education Collaborative Expert Panel 2011). Beyond the knowledge, skills, and attitudes associated with the direct provision of clinical care and the effective consultation techniques critical to effective integration of care (Katon and Unutzer 2011), psychiatric leadership in clinical oversight, delivery system design, training, and a wide range of additional administrative and policy functions may provide additional value to the care and care systems that emerge in transforming health systems. The relevant leadership skills for psychiatrists are addressed in other sections of this handbook, but must be incorporated into the functioning of any psychiatrist involved in integrated care. Psychiatric leadership in these areas is needed to ensure that appropriate expertise and guidance leads to incorporating evidence-based, recovery-oriented, and affordable approaches to treating mental illness and substance use disorders in all settings and addressing PC needs in BH specialty sites. Whether the psychiatrist's assigned roles are strictly clinical (including direct care and/or consultation) or encompass more explicit and overt administrative, planning, or policy functions, the key leadership qualities that psychiatrists embody are intangible assets for the clinical team, the healthcare provider organization, and the overall delivery system.

Appendix A: Comprehensive Preventive Health Screening for Adults with Serious Mental Illnesses

This appendix is designed to assist community psychiatrists in providing preventive disease services currently recommended for the general population, based on age, gender, smoking, and pregnancy status, with additional recommendations for screening services and/or medications for persons with SMI.

Recommended Universal Screening

Universal preventive health recommendations (USPSTF) based on gender, age, smoking, and pregnancy status are accessible at http://epss.ahrq.gov/ePSS/search.jsp, including a printable version. The USPSTF list is a reasonable baseline set of recommendations. Further services may be indicated based on personal history, family history, other known risk factors for preventable diseases, or individual patient characteristics.

Immunizations

A convenient and user-friendly guide for recommended adult vaccine schedules, assuming patients are up to date on recommended childhood vaccinations, is accessible at: http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm. Of particular note for persons seen in BH settings, where there is a high incidence of tobacco use, especially smoking, adults who smoke are considered to have chronic underlying lung dis-

ease and should be offered a pneumococcal (polysaccharide) vaccine once before the age of 65, and again at the age of 65 in addition to yearly influenza vaccinations.

Additional Preventive Services for Persons with Serious Mental Illnesses

Communicable Diseases

People should be offered screening at intake and annually for the following if risk factors exist or persist (De Hert et al. 2011): syphilis; tuberculosis, hepatitis B, and hepatitis C; HIV.

Cardiovascular Disease

Basic screening should occur similarly to the general American adult population, with additional screening as guided by individual risk factors (i.e., high-risk medications, smoking cessation, etc.).

High-Risk Medications

Some common medication classes and specific medications to consider in screening and monitoring for this population:

Second generation antipsychotics (American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists and North American Association for the Study of Obesity 2004):

Lithium: Renal, thyroid, pregnancy, fluid status, urinalysis, and complete blood count.

Valproic acid: Liver function tests (baseline and throughout), complete blood count with platelets, serum drug levels; prothrombin time/partial thromboplastin time, especially prior to surgery; serum ammonia if the person is lethargic or with mental status changes.

Tricyclic antidepressants: Blood pressure, pulse, weight, electocardiogram in older adults and those with previous history of heart disease.

First generation antipsychotics: AIMS every 6 months, some with EKG.

Metabolic, Nutritional, and Endocrinologic Deficiencies

Monitor for these deficiencies with the following screening tests/questions: complete blood count (anemia may present as depression); thyroid (may mask signs of depression, may be affected by some treatments); liver function tests (may be at elevated risk for nonalcoholic hepatitis, hepatitis, or alcoholism) (De Hert et al. 2011); vitamin B12 and folate (poor dietary intake); vitamin D (limited sunlight exposure or dietary intake); dexa scan: especially in those at equal risk to women above 65 years of age; questions about constipation and oral health (De Hert et al. 2011).

Endocrinological or Metabolic Disorders

These disorders may be addressed with the following treatments: multivitamin; folate (dosage: 400–800 μg/day), especially in women of childbearing age; thiamine (dose: 100 mg/day): there is a high co-occurrence in alcohol misuse disorders; vitamin D (dosage: 400 IU

Table 2. Recommended Monitoring Parameters for Patients Taking Atypical Antipsychotics[a]

Parameter	Baseline	4 Wk	8 Wk	12 Wk	Quarterly	Annually	Every 5 Years
Personal history	X					X	
Family history	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference						X	
Blood pressure	X			X		X	
FPG	X			X		X	
Fasting lipid profile	X			X			X

[a] *Additional or more frequent screening may be necessary based on a patient's individual risk and personal or family history.*
BMI: body mass index; FPG: fasting plasma glucose.
Source: Reference 19.

daily); and calcium (dosage: 1,000 mg elemental daily); omega-3 fatty acids that may help with depression and schizophrenia (no dosage range has been identified, doses above 3,000 mg/day should be used cautiously; Akter et al. 2011).

Intrapartum and Postpartum Period

Neonatal urine drug screen/meconium drugs of abuse on neonates born to mothers with serious mental illnesses or depression (De Hert et al. 2011); postpartum depression screening instrument; increased frequency of visits, higher monitoring of high-risk medications and exacerbation of symptoms.

Co-occurring Conditions

Alcohol and substance misuse; tobacco use. Adults with SMI should be offered counseling routinely, in addition to pharmacological/replacement therapies to assist in cessation (Allen et al. 2011).

Injury/Violence

Suicide risk; intimate partner violence; seatbelt use; helmet use.

Appendix B: Indications for Referral to PCP

Elevated Blood Sugar

Fasting blood sugar (serum) above100 mg/dL, two non-fasting (random) serum blood sugars above 200 mg/dL, or Hemoglobin A1C (non-fasting) above 6.5%.

Dyslipidemia

Fasting LDL above 130 mg/dL, total cholesterol above 240 mg/dL; HDL below 40 mg/dL. Triglycerides (fasting) above 150 mg/dL. The following website provides a useful step-by-step guide for screening, diagnosing, and treating dyslipidemias: http://www.nhlbi.nih.gov/guidelines/cholesterol/atglance.htm.

Hypertension

Two blood pressures above 140 mmHg systolic or above 90 mmHg diastolic greater than 1 week apart.

Metabolic Syndrome

Any three of the following:

Risk factor	Defining level
Abdominal obesity	Waist circumference
Men	>102 cm (>40 in.)
Women	>88 cm (>35 in.)
Triglycerides	≥150 mg/dL
HDL cholesterol	
Men	<40 mg/dL
Women	<50 mg/dL
Blood pressure	≥130/≥85 mmHg
Fasting glucose	≥110 mg/dL

Obesity is associated with insulin resistance and metabolic syndrome. The presence of abdominal obesity is more highly correlated with metabolic risk factors than an elevated body mass index (BMI). Therefore, the measurement of waist circumference is recommended to identify the body weight component of the metabolic syndrome. Some male patients develop multiple metabolic risk factors when waist circumference is only marginally increased, e.g., 94–102 cm (37–39 in.). They may have a strong genetic contribution to insulin resistance and should benefit from changes in life habits, similar to men with categorical increases in waist circumference.

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Part IV

Practicing: Core Clinical Competencies and Techniques

15 Cultural Competence

Russell F. Lim

Introduction

The diversity of the United States has increased dramatically over the last 20–30 years and will continue to change in the next 40 years. According to the US Census, between 1980 and 2000, the number of Asian Americans increased by 230%, American Indians by 139%, Hispanic Americans by 142%, and African Americans by 32%. In contrast, the Caucasian population increased by 11% (US Census Bureau 2000). Twelve percent of the US population is foreign born with one foreign born parent, indicating that one in four people in the United States is a first or second-generation immigrant (US Census Bureau 2010). Projections by the US Census Bureau indicate that the Hispanic population will double from 2010 population levels by 2050, accounting for an increase in percentage from 2010 of 15 percentage points from 16.3% to 31.3%, and the Asian population will increase by 79%. Also of note is that the biracial population is projected to double from 1.8% to 3.7%. The US population could be 50% minority and 50% White as early as 2040, assuming high net immigration or is projected to be 42% minority groups in 2050, assuming zero net growth in international migration (Ortman and Guarneri 2009).

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These population demographic projections have significant implications for community mental health, as many immigrant and minority populations have their mental health needs taken care of by the public sector, bringing up issues of Limited English Proficiency (LEP), the proper use of interpreters, understanding the patient's explanatory models, and the use of complementary and alternative medicine. Further, the Institute of Medicine's report, *Unequal Treatment* (Smedley et al. 2002), indicated that ethnic minority patients have reduced access to services and receive a lower quality of medical and psychiatric treatment than mainstream patients even when socioeconomic status is matched with mainstream patients. Providers in community and other public sector settings such as the Veteran's Administration or the Indian Health Service will need to develop a set of culturally appropriate and sensitive attitudes and assessment skills and learn culturally specific values and beliefs to properly assess and treat the many ethnicities and minority groups that will be represented in their patient populations.

This chapter defines cultural competence and recovery as well as reviews important national and Federal policy documents supporting its use in community psychiatry, and describes practical strategies on how to apply its principles, including the use of the *Diagnostic and Statistical Manual, Text-Revision*, Fourth Edition (DSM-IV-TR)'s Outline for Cultural Formulation (OCF), as well as describe culturally appropriate treatments adapted from evidence based practices.

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The chapter concludes with a discussion of examples of state and local legislation affecting the practice of culturally competent community psychiatry.

Stigma, Recovery, and Cultural Competence

Before addressing how to provide culturally appropriate care, we have to discuss the barriers that create the mental health disparities minorities experience that have been documented in *Unequal Treatment*, as stated above, the Surgeon General's Supplement to the Report on *Mental Health: Culture, Race, and Ethnicity* (USDHHS 2001), and the President's New Freedom Commission on Mental Health (2003). One major barrier is the stigma of mental illness, and it can be defined as a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and/or discriminate against people with mental illnesses. Stigma leads others to avoid renting to, living, socializing, and/or working with, or employing people with mental disorders especially people with severe disorders, which is then internalized, leading to low self-esteem, isolation, and hopelessness such that they conceal their symptoms and fail to seek treatment. At a systems level, it deters the public from seeking and wanting to pay for care. People of color, women, gays and lesbians, and/or of religious faiths other than Christian experience a "double stigma," that is to say that they are discriminated against for belonging to nonmainstream groups, and they still experience the stigma of having a mental illness.

Recovery-based practices can be thought of as the antidote to stigma, and can be defined as practices supporting a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence. The elements of recovery include the instilling of hope; the use of appropriate medication and treatments; client empowerment; the use of community support; mental health education; self-help, and spirituality/religion; and obtaining employment and participating in meaningful activity. Service providers can apply the principles of cultural competence to recovery-based treatment, which involves an acceptance of the culture that the patient considers to be theirs, and their experience in a culture that may not accept them as they are because of *racism, sexism, colonialism, or homophobia, and* may discriminate against them because of their gender, sexual orientation, religious beliefs, ethnicity, language, age, or country of origin. By acknowledging the differences between patients and the mainstream population, a provider can begin to build a patient's self-esteem and help them to develop coping skills to shield themselves from stigma and discrimination, making their community a safer place to be themselves. Strategies to achieve these goals include reducing the isolation caused by cultural differences and LEP by providing community and peer support, as well as linguistically appropriate services and mental health education, and even encouraging clients to learn more English. Cultural competence in recovery would mean creating patient-centered service plans, taking into account each person's individual cultural experience and avoiding stereotypical ideas that all people belonging to an ethnic group or speaking the same language have the same cultural beliefs. Trauma associated with discrimination, violence, or displacement must be acknowledged and addressed for healing to take place, as well as any medical needs, and substance abuse disorders. Treatment plans may include the use of traditional healers such as curanderos, shamans, medicine men, midwives, acupuncture, ayurvedic or herbal medicine, meditation, tai chi, and yoga, among others. Spirituality plays an important role and may or may not involve an organized religion and could be a belief in God, or a higher power, worshiping and respecting one's ancestors, or a belief in the spirit world. Recovery may also require the acquisition of new skills, job training, language proficiency, or obtaining decent housing, eligible entitlements and US citizenship. Finally, culturally competent recovery-based practices will help clients to reclaim their cultural identity that they may have tried to deny which would reduce their feelings of alienation from the mainstream. By providing support to culturally diverse individuals and valuing their differences, providers in the community can promote healing through self-acceptance, and stop the internalization of stigma (Ida 2007).

Definitions

The practice of culturally appropriate assessment and treatment can be described as being culturally competent, as first defined by Cross et al. (1989). Although there are many definitions, the one that may best capture the spirit of cultural competence is the definition stated by the Center for Mental Health Services (CMHS), which states that it has five principles, (1) accepting and respecting differences, as opposed to saying that all patients are the same, (2) continuing self-assessment of the clinician's attitudes towards culture and cultural differences, (3) paying attention to the way that differences or similarities between clinicians and patients affect the interaction, (4) learning about cultures and acquiring culturally specific resources, and (5) creating services that are culturally appropriate for the population served (SAMHSA 2001) (Table 15.1).

Table 15.1 Definition of cultural competence

Acceptance and respect for differences
Continuing self assessment regarding culture
Attention to the dynamics of difference
Ongoing development of cultural knowledge and resources
Dynamic and flexible application of service models to meet the needs of minority populations

Source: SAMHSA (2001)

Another important concept is cultural humility, defined by Tervalon and Murray-García as a lifelong process of self-reflection and self-critique. The provider of culturally appropriate care is encouraged to develop a respectful partnership with each patient through person-centered interviewing, that explores similarities and differences between his or her own and each patient's priorities, goals, and capacities. Ideally, the conclusion of this cross-cultural exploration would be to develop an approach to managing clinical problems based on negotiation between the two culturally distinct perspectives. A culturally competent provider is open and flexible enough to identify the importance of differences between his or her orientation and that of each patient, and to explore compromises that would be acceptable to both. Thus, a clinician applying the principles of cultural humility would not expect himself or herself to be an expert in cultural minutiae, or to take on other healer's roles such as a minister or an herbalist, but recognize the need to refer a patient for appropriate services or obtain appropriate consultation (Tervalon and Murray-García 1998).

Before I proceed further, I should define the terms culture, race, and ethnicity. Culture can be defined as a set of values, traditions, and beliefs that are passed from generation to generation. Race is not biologically determined, but is a socially defined concept that groups individuals on the basis of skin color and other physical features. Ethnicity is the group that one feels one belongs to, and overlaps with culture. Therefore, within the group who self-identify their ethnicity as Chinese, there may be other cultures represented, based on regional, political, and historical differences. Conversely, cultures can cut across ethnicities, for example, Western, military, or medical cultures.

Federal Policies and National Standards

The Federal government, as represented by Congress, and the agencies they fund, determines funding priorities and therefore the shape and form of the delivery of services. In 1998, the US Department of Health and Human Services (USDHHS) Office of Minority Health (OMH) conducted a national level review of existing cultural and linguistic competence standards and measures in order to prepare and draft of national standards, known as the CLAS (Culturally and Linguistically Appropriate Services) Standards (Office of Minority Health 2000). The standards were informed by a careful review of key legislation, regulations, contracts, and standards currently in use by Federal and state agencies and other national organizations. The proposed standards were then developed with input from a national advisory committee of policy administrators, healthcare providers, and health services

Table 15.2 National standards for culturally and linguistically appropriate services (CLAS)

Culturally competent care

Health care organizations:

1. Should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language
2. Should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area
3. Should ensure that staff at all levels and across all disciplines receive ongoing education and training in CLAS delivery

Language access services

Health care organizations must:

4. Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency (LEP) at all points of contact, in a timely manner during all hours of operation
5. Provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services
6. Assure the competence of language assistance provided to LEP patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)
7. Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area

Organizational supports for cultural competence

Health care organizations should:

8. Develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide CLAS
9. Conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations
10. Ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated
11. Maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area
12. Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS related activities
13. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers
14. Be encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information

Source: Adapted from Office of Minority Health (2000)

researchers. Fourteen standards were created, defining culturally competent care, i.e., care that is compatible with cultural health beliefs, and in the preferred language, how to provide services in the appropriate languages for the client. These standards included providing signage, literature, and interpretation in the patient's preferred language so that family members do not have to be used as interpreters, and supporting cultural competence in the organization, such as strategic planning that specifies hiring and retention practices that encourage diversity such that staffing matches the patient population, with training in cultural competence principles, like working with the community and having ongoing assessment of cultural competence practices, demographics of the patient population, and a review process that is available to the public (see Table 15.2).

The first report on culturally competent mental health care created by a government agency was *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups* first published in 1998 by the Western Intercollegiate Commission for Higher Education, and later distributed by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2001), which detailed overall system standards and implementation guidelines, such as cultural competence planning, community outreach and education, and quality monitoring and improvement, as well as human resource development. These also included clinical standards, such as access, triage, assessment, treatment, and discharge planning, and case management. Finally, the report delineated guidelines for communication and patient self-help and carefully outlined the provider competencies of culturally specific knowledge, and culturally generic attitudes, and skills.

In 2000, the Office of Civil Rights (OCR), empowered by White House Executive Order 13166: "Improving Access to Services for Persons with Limited English Proficiency," required that all Federal agencies formally address how they would provide access to their services to people with LEP. The USDHHS issued guidance that included an "Effective Plan on Language Assistance for LEP Persons," stating that programs receiving Federal funds must (1) identify individuals who need language services, (2) have language assistance services, (3) train staff to appropriately work with clients who need language assistance, (4) provide notice for people that services are available, such as signs in their language, and (5) that such programs must be monitored and updated (USDHHS 2000).

The next report to be released was the Supplement to the Surgeon General's Report on Mental Health, *Mental Health: Culture, Race, and Ethnicity* (USDHHS 2001) in 2001, which established that ethnic minorities do not utilize mental health services as much as the majority population and that "culture counts." The supplement documented striking disparities in mental health care for racial and ethnic minorities involving access to care, appropriateness of treatment, overall quality of care, and treatment outcomes, as well as the fact that minorities are poorly represented in research studies. Together, these mental health disparities impose a greater burden of disability on racial and ethnic minorities. Some examples from each of the four chapters on the major racial and ethnic groups follow:

- Disproportionate numbers of African Americans are overrepresented in the most vulnerable segments of the population—people who are homeless, incarcerated, in the child welfare system, victims of trauma—all populations with increased risks for mental disorders.
- As many as 40% of Hispanic Americans report that they have LEP. Because few mental health care providers identify themselves as Spanish-speaking, most Hispanic Americans have limited access to ethnically or linguistically similar providers.
- The suicide rate among American Indians/Alaska Natives is 50% higher than the national rate; rates of co-occurring mental illness and substance abuse (especially alcohol) are also higher among Native youth and adults. Because little data has been collected, the full nature, extent, and sources of these disparities remain a matter of conjecture.
- Asian Americans/Pacific Islanders who seek care for a mental illness often present with more severe illnesses than other racial or ethnic groups. This, in part, suggests that stigma and shame are critical deterrents to service utilization. It is also possible that mental illnesses may be undiagnosed or treated later in their course because they are expressed in symptoms of a physical nature (Tervalon and Murray-García 1998).

The report concluded with "A Vision for the Future," in which recommendations were grouped in six areas: (1) continue to expand the science base, (2) improve access to treatment, (3) reduce barriers to treatment, (4) improve quality of care, (5) support capacity development, and (6) promote mental health.

In 2003, the President's New Freedom Commission on Mental Health issued its report entitled *Achieving the Promise: Transforming*

Mental Health Care in America (New Freedom Commission on Mental Health 2003). Through this document, the Bush Administration created policy to guide how mental health and health professionals ought to be recruited and trained to deliver services to diverse populations. Of the six goals discussed as strategies to transform the mental health system, two are most relevant to minority mental health disparities: (1) mental health care is consumer and family-driven and (2) disparities in mental health services are (to be) eliminated. Some of the specific recommendations included improving access to quality care that is culturally competent by (1) recruiting and retaining racial and ethnic minority and bilingual professionals, (2) developing and including curricula in all Federally funded health and mental health training programs that address the impact of culture, race, and ethnicity on mental health, (3) developing training and research programs targeting services to multicultural populations, (4) engaging minority consumers and families in workforce development, training, and advocacy.

Finally, in 2005, the National Institutes of Health (NIH), along with the National Institute of Mental Health, instituted a policy that all investigators must describe how they will recruit underrepresented groups, such as ethnic minorities, women, and other nonmajority groups in their experimental protocols. According to the guidance, "NIH also requires a description of the proposed outreach programs for recruiting sex/gender and racial/ethnic group members as subjects (NIMH 2005)." Thus, investigators are required to describe how they will recruit subjects that represent all of the major underrepresented groups, and not just the mainstream and majority group, or risk not being approved for research funding.

Clinical Approaches

Staff Training: Diversity Training vs. Cultural Competence Training

Staff that provide mental health services to a diverse population requires training that encompasses culturally relevant knowledge, attitudes, and skills. Cultural knowledge can be obtained from books, such as *Ethnicity and Family Therapy*, by McGoldrick et al. (2005), but these references can also be used to create stereotypical lists of qualities and generalities that trainees memorize, and may give trainees a false sense of security that they "know" everything about a particular group after reading a single chapter. The references may provide give a good starting place for trainees to understand what is normative for an ethnic group, and how to begin asking more culturally pertinent questions to understand the client that they have in their office.

In order to use resources such as *Ethnicity and Family Therapy*, clinical staff and trainees should have diversity training, which helps them to develop attitudes that are accepting of cultural differences, then cultural competence training that teaches culturally-generic skills, and then culturally-specific knowledge. The reader interested in designing a training program in diversity and cultural competence is referred to the excellent books suggested as resources at the end of this chapter.

Concerning the training in attitudes, it is my view that cultural competence training for staff begins with creating an atmosphere where differences are acknowledged and celebrated. This begins with hiring staff from representative groups to allow the cultural perspective to be shared with other staff members, as well as providing culturally appropriate assessment and treatment planning, a process which begins with the use of the DSM-IV-TR OCF, as discussed in the next section. Briefly, this means taking a person-centered approach, with a focus on his or her cultural identity, as well as personal models of illness and expected treatment; not just using the DSM-IV-TR as a basis for diagnosis, but using a more culturally relevant approach, such as finding out what name the patient gives to their condition. The clinic can have case conferences that highlight the cultural aspects of cases, and provide much needed examples. The clinical environment should have signage in the appropriate languages and artwork representative of the patient population.

Diversity training exercises help staff to recognize similarities and differences in themselves,

Table 15.3 Discussion questions from *understanding race, ethnicity, and power*

What was your first experience with feeling different?
What is your ethnic background? What has it meant to belong to your ethnic group? How has it felt to belong to your ethnic group? What do you like about your ethnic identity? What do you dislike?
What are your feelings about being White or a person-of-color? How do you think others feel?

Adapted from Pinderhughes (1989)

Table 15.4 The *Diagnostic and Statistical Manual, Text-Revision* (DSM-IV-TR) outline for cultural formulation (OCF)

A. Cultural identity of the individual
B. Cultural explanations of the individual's illness
C. Cultural factors related to psychosocial environment and levels of functioning
D. Cultural elements of the relationship between the individual and the clinician
E. Overall cultural assessment for diagnosis and care

Source: American Psychiatric Association (2000)

and become aware of subtle prejudices and biases that staff may have. A common 1-hour training exercise is to have staff introduce themselves in groups of six to eight, but in a way that does not only just chronicle their training and jobs, but reveals where they are from, what languages they speak, and what are the important parts of their identity. They may even talk about the origin of their names and its meaning(s). On another occasion, a potluck can be scheduled when staff may also bring in a comfort food or cultural healing practice, such as chicken soup, from their cultural group, explain to others what is in it, and how their family explained to them how it would help to make them feel better. Another approach is to celebrate ethnic holidays, such as Chanukah, Chinese New Year, Cinco de Mayo, Kwanzaa, and Ramadan, and have a brief presentation on the holiday's meaning and customs. Finally, an hour can be taken with a group of eight to explore discussion questions from *Understanding Race, Ethnicity, and Power* by Pinderhughes (1989) (Table 15.3).

DSM-IV-TR Outline for Cultural Formulation

The *Diagnostic and Statistical Manual*, 4th Edition (DSM-IV) (American Psychiatric Association 1994) and DSM-IV-TR [Text Revision] (American Psychiatric Association 2000) both include Appendix I, which includes the DSM-IV OCF and a glossary of culture bound syndromes, which are diagnostic descriptions that may be understood in the context of local cultural beliefs, and can be variants of diagnoses seen in clinical practice in the United States and other Western Countries, such as neurasthenia, a somatic variant of major depressive disorder, that is used in the *Chinese Classification of Diseases*, 10th Edition. The DSM-IV-TR OCF is a useful framework for organizing a culturally sensitive assessment of a culturally diverse patient, and it contains the following five sections: Part A is the cultural identity of the individual, Part B is the cultural explanations of the individual's illness, Part C includes the factors related to psychosocial environment and levels of functioning or supports and stressors, Part D is the cultural elements of the relationship between the individual and the clinician, and Part E is the overall cultural formulation, which integrates both the patient's and clinician's models of illness and treatment (Table 15.4).

Part A: The Cultural Identity of the Individual

Asking a patient about their cultural identity can be accomplished by performing a social and developmental history with attention being paid to the patient's country of birth, ethnicity of his or her parents and grandparents, and language(s) spoken. Ethnicity may also be assessed by asking the patient directly: what his or her name means, or what is his or her ethnic background? The "Addressing" framework from Hays (2008), can be useful here, as a checklist of things to explore, using the letters of the word "Addressing" in the following way: "A" is for age and generational influences, and is useful for examining the interaction between generations, especially when the parents are from another country, and the patient

Table 15.5 Addressing framework

Age and generational influences
Developmental and acquired
Disabilities
Religion and spiritual orientation
Ethnicity
Socioeconomic status
Sexual orientation
Indigenous heritage
National origin
Gender

Source: Hays (2008)

Table 15.6 Kleinman's eight questions

What do you call your illness? What name does it have?
What do you think has caused the illness?
Why and when did it start?
What do you think the illness does? How does it work?
How severe is it? Will it have a short or long course?
What kind of treatment do you think the patient should receive? What are the most important results you hope she receives from this treatment?
What are the chief problems the illness has caused?
What do you fear most about the illness?

Source: Kleinman et al. (1978)

is the second generation here. "D" is for developmental and acquired, and the second "D" is for disabilities, another aspect of differences. "R" is for religion and spiritual orientation, a very important aspect of a patient's identity. "E" is for Ethnicity, and it is important for clinician to understand how ethnicity is different from nationality, because a patient can have a different ethnicity that may be expected just from the nationality. "S" is for socioeconomic status, which is an important parameter in an individual's experience of their life. "S" is also for sexual orientation, which must be directly assessed, as it is easy to assume that a patient is heterosexual. "I" is for indigenous heritage, or culture that is passed down. "N" is for national origin, which is important to determine what environment that the patient experienced as a child and young adult, but is insufficient in and of itself, as national origin or nationality does not necessarily equal ethnicity. "G" is for gender, as men and women have different gender roles to fulfill, and may not feel comfortable with them. Finally, I would add an "L" to the mnemonic for language, as many patients speak a variety of languages, but prefer one to the other (Table 15.5).

Part B: Cultural Explanations of the Individual's Illness

The clinician's task is to identify how the person understands his or her illness, not only how symptoms fit into the DSM-IV-TR diagnostic criteria. Kleinman et al. (1978) wrote about the distinction between the disease, which is an observable physical phenomenon, and the illness, which is how the patient experiences the disease through his or her cultural viewpoint. They went on to describe a set of eight questions that involve asking the patient what they think is the explanation for their illness: its name, how it works, how severe it is, and what problems it has caused. The clinician continues by asking about what kind of treatment is expected, both by the person and by the person's family (see Table 15.6). By inquiring about the person's understanding of the illness in their terms, clinicians can gain important insights into how people understand their disease and gain information that will be useful in the negotiation of their treatment with the person. At this time, the clinician may inquire about other healers that the person may have consulted prior to coming to the clinician's office, as many cultural groups have indigenous healers or alternative explanations for the causes of illness. The clinician can then inquire about herbal or organic treatments that may not be compatible with prescribed medications, as well as show interest in the person's journey into health.

Part C: Cultural Factors Related to Psychosocial Environment and Levels of Functioning

Part C of the OCF includes the cultural factors involving the individual's supports and stressors, and they can be assessed during the taking of the developmental or social history. In this section, we as clinicians would like to understand how an individual fits in or not with his or her community and extended family and his or her primary

social supports. Important things to ask about are the person's primary relationships, educational level, occupational, functional levels, and goals. Also important is relationship to parents, aunts and uncles, cousins, and religious community. Patients may have ambivalent relationships between their parents and/or religious/ethnic communities, such that the very group that they derive their support from is also a stressor. Religious beliefs are a part of an individual's cultural identity and must be explored because they may guide his or her decision-making about mental health treatment. The extended family may be the last word in deciding if a course of treatment may be followed or not.

Part D: Cultural Elements of the Relationship Between the Individual and the Clinician

The fourth part of the DSM-IV-TR OCF refers to how the cultural identity of the therapist affects the therapeutic relationship. The most common situation seen is when the patient is a minority and the clinician represents the mainstream culture. The patient may be reluctant to engage with the mainstream clinicians over feelings that the therapist may not understand their experience, or in fact, be biased against them. Or they may be very deferential to the clinician, while not completely agreeing with him or her indicating agreement while actually not following the therapist's advice, not wishing to confront the therapist because of culturally determined roles involving a deference to authority figures. With more minority therapists being trained, the dyad may be matched in some ways, but not in others, and there may be a false sense of security on the therapist's part that they understand the client, and that they do not have to ask particular questions, because the answers are already known by the therapist, due to his or her knowledge of their shared culture, or that parts of the history are too sensitive to talk about as agreed upon by their shared cultural group. Patients may also react to the clinician with an overly positive transference, feeling that their clinician is omnipotent and can offer relief from their symptoms and causing strong negative feelings when it is discovered that the clinician has human frailties or otherwise disappoints. In other situations, the patient may dislike his or her same ethnicity therapist, and request one who is more mainstream with the belief that, as that therapists of his or her own race are inferior to mainstream therapists, a projection of their internalized racism, referred to by Comas-Diaz and Jacobsen (1991) as "auto-racism."

Part E: Overall Cultural Assessment for Diagnosis and Care

The final part of the DSM-IV-TR OCF is the overall assessment for diagnosis and care, which involves integrating Western illness concepts and the patient's explanatory models and adressing information gathered in the first four parts, such as their cultural identity, stressors and supports, and their relationship with the clinician, along with skillful negotiation of the treatment plan using the both Western and indigenous explanations of illness, using the clinician as the bridge between them. Having the services of a cultural consultant or cultural broker, or a clinician familiar with the cultural group of the person can be helpful in determining cultural norms, simplifying the discussion of what is cultural and what is pathological. The consultant provides an important context for the interpretation of symptoms, of illness and healing beliefs and practices, and understanding of the person's role in family, community, and dominant culture. There are three good examples of cultural consultation services, one in Montreal, QC in Canada (Kirmayer et al. 2003), and one in Sacramento, CA (Ton et al. 2005), and London, England (Cultural Consultation Service 2012).

Applications of Culturally Effective Treatment

In this section, through examples, I will further illustrate the clinical principles described above and how the key to engaging people in ethnic minorities into mental health services is to combine the principles of adapting services and systems to population needs, understanding and

accepting their cultural beliefs about illness, and where applicable, employing the principles of ethnopsychopharmacology.

Southeast Asian Communities

David Kinzie wrote about *The Therapist Variable* in which he described the trauma experienced by Southeast Asian patients, and that they have four primary needs, safety, both physical and emotional, predictable and stable relationships, reduction of symptoms, and the reestablishment of social relationships (Kinzie 2001). According to Kinzie, the therapist must be able to listen to a person's trauma without interruption, and be present as a dependable and stable relationship. The therapist is required to believe the evil that humankind has done to their fellow humans, yet still believe that healing is possible, and to receive gifts of modest value from traumatized Southeast Asians, such as prayers, seasonal dishes or social invitations, despite training to not accept gifts of any kind, as it is therapeutic for them and represents a culturally appropriate way for a person to honor the therapist–patient relationship.

Hinton and Otto described a way of modifying Cognitive Behavioral Therapy (CBT) for the treatment of post traumatic stress disorder (PTSD) in Cambodians who conceived of their illness as being caused by bad "wind" or muscle tension or dizziness, which may have been caused by forced labor, chronic starvation and sleep deprivation experienced in the killing fields (Hinton and Otto 2006). *Wind* is conceived as a source of energy flowing through the body, and a loss of wind, signified by tension in a joint would lead to bad health outcomes, like the death of the limb away from the tension due to the lack of blood flow, and to the dangerous ascent of wind and blood in the body, into the trunk of the body. The catastrophic cognition would be that this wind could cause a heart attack or the person's breathing to stop, or rupture of the blood vessels in the neck or into the head, leading to fainting, blindness, or death. Treatment for the bad wind would be "cupping" or causing redness on the skin by applying negative pressure thorough a heated glass bulb applied to the skin, or coining, using coins to rub the skin, causing a round red mark on the skin. In the adapted CBT protocol, the therapist introduces the "Limbic Kid" to explain the automatic responses and thoughts associated with the catastrophic cognitions (Otto and Hinton 2006). The therapist then induces dizziness by having the person play a childhood game called "hung," where she or he holds his or her breath while running to retrieve a stick, experiencing dizziness, but no other ill effects, allowing a disconnection of the physical sensation from catastrophic cognitions. Finally, the therapist incorporates a Buddhist ritual, the three bows, with three statements. Thus, the first bow acknowledges the pain. The second is the acceptance that it has lingering effects, and the third is returning a focus to the present, and planning to have a good life in the present.

Another example is a Vietnamese support group that used principles of wellness and adaptation to the host culture by serving tea, doing relaxation exercises, and teaching English to the members (Truong and Gutierrez 2009). The group leaders, third year psychiatry residents who were ethnically Vietnamese and bilingual in Vietnamese and English, found that the group members were willing to share in a group format, despite predictions found in the literature that Asians would not feel comfortable in groups due to cultural prohibitions against sharing private matters (Paniagua 2005), showing again that one cannot predict the behavior of all Asians with generalizations about an entire ethnic group that is heterogeneous.

Hispanic Communities

Other examples of groups treatment for ethnic minorities include CBT for depression adapted for use in Spanish speaking patients (Miranda et al. 2006). Miranda and her colleagues reported that in an ethnically diverse clinical population diagnosed with major depressive disorder, those randomized to CBT or medication management did better than those referred to a community mental health center (Miranda et al. 2006). The authors noted that community outreach was needed to educate people about their illness and the types of treatment. Despite providing transportation and childcare, only slightly over one

third were able to attend more than six sessions that had been appropriately translated to Spanish for those who were monolingual, illustrating the difficulties encountered by study subjects in making appointments. The group taking medications did slightly better, implying that psychopharmacology was still effective, but less so without outreach and support.

Ruiz and Langrod identified the importance of spiritual beliefs in the Hispanic population of the Bronx, and in order to increase the engagement of this clinic with the community, recruited mediums, accepted referrals from and referred cases to mediums, actively outreached to the community by visiting spiritual centers, conducting ethnographic observations, and exchanging views of treatment and explanatory models with *espiritistas* and other spiritual authorities (Ruiz and Langrod 1976). Barrio (2000) similarly describes the importance of outreach to and engagement of the family and community through community support centers, which can bridge gaps between the community mental health center and the ethnically diverse populations they serve.

Using Systems to Aid Culturally Competent Services

Another strategy, similar to Barrio's description of creating systems linkages, is using access services, usually provided by community agencies that can provide language translation services. For example, Asian Pacific Community Counseling in Sacramento, CA provides language and culturally appropriate psychotherapy through the Transcultural Wellness Center (Asian Pacific Community Counseling 2011), but also serves as a linkage for people to enter the county mental health system (Sacramento County-Specialty Mental Health Services 2011). Finally, another approach that has been helpful in linking ethnic minority patients from the community to mental health services has been the Bridges program at the Charles B. Hwang Community Health Center (CHC). This model capitalizes on systemic integration of physical health and mental health services (discussed in detail in Chapter 14) at the Charles B. Hwang CHC. Chinese patients seen in primary care are referred to mental health professionals in the same building as their primary care colleagues, thus reducing the stigma they might experience if they were to be referred to a free standing mental health clinic (Chen et al. 2003).

Ethnopsychopharmacology

Ethnopsychopharmacology is the study of how ethnicity affects the activity of psychoactive agents. In a recent article, Chen et al. (2008), explain that there are many biological, environmental, and psychological reasons for the broad range of responses seen in different ethnic groups. The hepatic enzyme, cytochrome P450 and its subtypes CYP2D6, CYP3A4, CYP1A2, CYP2C19, and CYP2B6 are responsible for the metabolism of many psychotropic medications. Depending on the number of copies of genes coding for these enzymes, a person may be a slow metabolizer, where a small amount of a medication can have as big an effect as a normal dose, or a normal dose may have intolerable side effects. A person may be an ultrafast metabolizer, when even a large dose of medication can be experienced as not taking the medication at all. Diet and smoking also affects the drug metabolism, sometimes inhibiting or accelerating its rate. Finally, the patient's expectation of how the drug will work may affect the perception of the actual effect, or may cause an effect of its own (the placebo effect). On a clinical level, psychiatrists and primary care practitioners are well advised to start with a low dose and advance titration slowly in case the patient is a slow metabolizer. Genetic screening tests are available that can genotype a patient with a cheek swab sample, making it possible to predict the activity of a particular enzyme and adjust dosages accordingly (AssureRx 2012).

Culturally Competent Interventions at State and Local Levels

Clinicians need to have the support of their organization to provide culturally sensitive mental health services, as either seen by an application

of the CLAS standards or other systematic cultural competence framework. California has an excellent example of a mental health specific plan for culturally competent care in its California Cultural Competence Plan. In 1993, California began the process that became known as the California Cultural Competence Plan (California DMH [Department of Mental Health] 2003). Each of the 58 California counties had to assess the percentages of the languages spoken by their patients and providers, and were required to provide services and brochures in any language spoken by 3,000 Medi-Cal (California's version of Medicaid) members or 5% of the Medi-Cal population in that county. County agencies are required to monitor their staff composition and ensure that their staff diversity mirrors the patient diversity. The Cultural Competence plan also requires that training in cultural competence be provided for mental health clinicians on a continuing basis. Washington, California, Connecticut, New Jersey, and New Mexico all require continuing medical education courses include material on cultural competence, or require cultural competence training as a condition of licensure for physicians (USDHHS Office of Minority Health 2010).

Conclusions

US population projections by the US Census Bureau show that the number of minorities will increase at a higher rate than the general population, and in fact equal the majority population between 2040 and 2050. Community mental health providers will see the majority of these patients, as they are likely than mainstream patients to be under or not insured, particularly if they are indigent or newly immigrated to this country. The Federal government and states like California provide guidance on how to adapt our mental health services to meet the needs of the diverse populations that they serve. On a practical level, application of the DSM-IV-TR OCF can inform the clinician's assessment and treatment planning, using a culturally-appropriate skills based interview, informed by culturally-specific knowledge, perhaps provided by a cultural broker or consultant, and the engagement of the patient and their family in discussing their illness beliefs and practices. A careful review of the literature reveals examples of how evidence based practices such as CBT for depression can be adapted to different language and cultural groups, and the importance of enlisting community support, linkage, and providing outreach, education, childcare, and transportation if possible, as well as the importance of using religion and spirituality when appropriate, and complementary and alternative medicine, or other culturally appropriate treatments, as well as using principles of ethnopsychopharmacology, in terms of starting with small doses, and noting the effects of diet and smoking on the metabolism of psychotropic medications. By taking a holistic, culturally competent, and patient centered approach, the community clinician can deliver effective and culturally appropriate recovery based mental health care.

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Context-Specific Assessment

16

Stephen M. Goldfinger and Jacqueline Maus Feldman

Introduction

To appropriately evaluate people in their communities requires careful consideration of a panoply of contextual parameters. These are composed of a welcoming and safe ambience; physical plant characteristics; the clinical setting (e.g., inpatient, outpatient, emergency room, homeless shelter or under a bridge, correctional setting); whether the assessment is routine, urgent, emergent, or investigatory; the nature of the evaluation's expected product; and the cultural attributes of people, their communities, and the evaluator. Consideration of all these contextual issues will expand the evaluator's capacity to establish a therapeutic alliance, and to engage the patient in the assessment, and possibly treatment. Awareness of and responses to these contextual concerns will improve both the evaluative process and the evaluation product.

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An Assessment: Initial Considerations

Establishing the Interview Ambience

Approaching patients in a variety of settings is considered later in this chapter; however, establishing a comfortable and comforting physical and emotional space is the same, irrespective of setting and circumstance. As described in Chap. 8, how people are made to feel when they enter a clinical enterprise can influence the clinical process of their assessment. A return visit to a psychopharmacology ambulatory care clinic may arouse little discomfort, especially if protocols and staff members are consistent. Being greeted by a familiar clerk, sitting in a spacious waiting room with ready access to magazines, TV set on soft volume, toys for the kids, being called back by a gracious nurse and a physician with whom one has worked for many years allows for relatively calm, organized assessments. Disruption of protocols and expectations (new staff, loud baby banging his pacifier, cramped clinic space packed with agitated patients with active psychosis, a rushed doctor, fear of being unable to pay for one's medicines) may inhibit further assessment, or make it more likely to be hurried and superficial. Clinic setting characteristics can be subtle and nuanced, but are important and significant contextual considerations in whether the clinical setting is perceived as calm, warm and welcoming, or chaotic and inhospitable.

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Hook et al. (2009) provide a detailed summary of parameters that must be considered when conducting mental health assessments. Each individual should be approached with respect, composure, empathy, and an appreciation of personal boundaries. Attention to language proficiency and the potential need for interpreters are imperative. Not every person who speaks a unique language will receive an on-site face-to-face interpreter, but telephonic interpretation services are often accessible. All interviews should begin with a personal introduction; addressing someone as Ms. or Mr. (or professionally if a doctorate degree is involved) reflects a more formal relationship and recognition that the patient is deserving of politeness and respect. Some interviews begin with a handshake, others do not; regardless, initiation of an interview that allows for some privacy and personal attention can make chances of a successful evaluation greater. Eye contact should be appropriate, empathic engagement practiced, and at all times interviewers should be mindful of nonverbal cues. Tempering one's word choices, though never in a patronizing fashion, to the perceived or actual educational or intellectual level of the patient will also facilitate communication (Andrews 2008).

Safety Issues/Physical Space

Until the patient and provider both perceive they are out of harm's way, it is difficult for an assessment to proceed. Attention to a physical space that is welcoming, safe, and comfortable for someone with mental illness can prove to be a challenge, but it is well worth the time and effort (Hendricks et al. 2010) Setting up assessment space that ensures some privacy communicates recognition that boundaries and confidentiality are important. Patients with paranoia are often hypervigilent to boundary violations, so not only do they desire privacy but they also want sufficient space between them and the interviewer to minimize feeling physically threatened. Positioning of the examiner between patients and the door (e.g., not facilitating egress from the room) may make them feel trapped, which can inflame anxiety. The interview room/space should be furnished with an eye to minimizing objects that can be thrown or used for self-or-other injury. For example, psychiatric patients should not be placed in emergency department (ED) trauma rooms with access to needles or scalpels, emergency medicines, gauze or inhalants. Assessments should be conducted in areas of quiet and little traffic so as to minimize distractions and limit intrusions. It is important, however, to have security personnel rapidly accessible if the interviewer suspects or expects aggressive behavior (Hendricks et al. 2010).

The Nature of the Assessment, and the Expected Product

The nature of the clinical assessment is also driven by the clinical question (why is this person presenting?), and the expected product from the assessment. A leisurely three-session evaluation of a person who is concerned about sleep and anxiety differs vastly from an emergency room assessment of a patient brought by the sheriff's office because she/he is aggressive and psychotic. The clinician might be wise to ask, "What are the goals of *this* assessment?" Answering this contextual question will guide the assessment process.

Every evaluation shares at least two goals, regardless of context: establishing rapport, and developing a collaborative doctor–patient relationship (Andrews 2008) The process and product of the *rest* of the assessment will be predicated, in part, on the clinical context: where is the evaluation occurring and under what circumstances (the clinical status of the patient and what clinical question is being asked and by whom).

Types of Assessments, Contextual Considerations

Routine: Although routine evaluations can also occur under a bridge and in a homeless shelter, if the assessment is a prescheduled, voluntary, routine initial clinic visit to evaluate a proscribed symptom, the setting will typically be in an office where the person will probably hope to have a

diagnosis and treatment plan by the end of the session; this applies regardless of whether this is an evaluation by a private sector provider or one working in a mental health center, Department of Veterans Affairs (VA) facility, or correctional setting. One or several assessment visits may ensue; the patient will be engaged, key information will be elicited, including old records or information from referring practitioners, and treatment, if necessary, will be recommended and follow-up established. If the person is entering a system of care, education regarding confidentiality within the system should be made clear. For example, it is important to apprise patients that electronic health records are shared amongst all treatment team members in the VA, or that the warden may read an inmate's chart. Special attention must be paid to techniques of engagement when working with populations that have developed mistrust of systems of care, such as people who are homeless; providers should understand that engagement is long-term ongoing process, and that multiple neutral (focusing not on mental health per se), time-limited meetings may be necessary to lay the groundwork for therapeutic alliances (Ross and Gholston 2006).

Investigation: A one-time investigatory assessment will be somewhat different. Examples of such assessments are referrals for disability determination, custody, competency, or other legal questions. These are also typically prescheduled, usually occurs in an office setting, may be voluntary but is sometimes mandated, and often results in production of a report to the referring agency (e.g., Social Security Administration, public assistance authorities, child services, the court system); as such, engagement and a therapeutic alliance might be more difficult to establish. Individuals in these settings may be very symptomatic, exaggerating, minimizing, demanding, angry, or prevaricating, depending on the situation and follow-up treatment is typically not a goal. The objective of these sessions is to do as thorough an evaluation as possible while helping a person maintain a calm affect. The provider is ethically mandated to ensure the person is aware of the nature of the exam, and should get consent for release of information to the referring agency.

Urgent: Sometimes individuals will present needing an urgent (needs to be seen today) evaluation. Perhaps their symptoms are of an acute, debilitating nature, or they have sustained an abrupt physical or emotional trauma. Some systems of care have the capacity to respond quickly to the need for rapid evaluations, but most often these patients present to or are referred to emergency health care providers. These evaluations will focus on the presenting clinical question (e.g., the patient is a victim of rape, the patient has missed his last three shots and is becoming increasingly psychotic and hostile, the patient has consumed 3 six-packs and is now suicidal), and the evaluation may be tailored to spotlight the more salient issues while minimizing others. Concerns regarding affective lability, organicity, and impulsivity/unpredictability must be addressed. Safety is paramount, and establishing security protocols in advance can reduce the possibility of patient or staff injuries. In the face of a confusing presentation that needs a speedy evaluation, collateral information and substantiation, and/or organic workups are often overlooked, but may play a vital role in attempting to assess the nature of the acute presentation. Admitting to a psychiatric ward a confused and agitated patient with psychosis who is then found to have a fever of 103, pneumonia, and a pO_2 of 42 reflects an incomplete urgent evaluation that places the patient, and the system of care, at risk. Hendricks et al. (2010) offer an excellent blueprint and review of approaches to patients and situations that need crisis intervention. Diamond (2002) offers an extensive review of medical illnesses that can have mental health presentations.

Emergent: Psychiatric patients do present who need to be evaluated quickly (not just today, but right now). Often they are brought for evaluation by family or caregivers who report uncontrolled agitation or combativeness, suicidal or homicidal ideation with intent and/or plan, profound confusion, or some other acute clinical change or onset. The evaluation may or may not be voluntary. Unless a mental health facility has access to emergent medical care, it is most prudent to move these patients to an emergency medical facility (by ambulance). Often, these patients are grossly

agitated, confused, or mute, and direct communication may be difficult, if not impossible. Setting a calm tone in the evaluation space (ED, office, jail cell, tent under the bridge) is imperative. Soft speech, slowed physical movements, and a relaxed demeanor help the person, and the rest of the treatment team, calm down. However, if these strategies have limited success, last-resort utilization of security methods, such as mechanical or chemical restraints may be necessary. Giving the person a heads-up on what will be occurring, and explaining while restraints are being applied or administered might feel like an exercise in futility. However, it is possible a person is aware of the situation and environment, and these explanations show humanism, personal respect, and procedural justice. They may prove reassuring and, in the end, helpful for eventual engagement. Certainly processing the need for restraints after the event has resolved is important. Especially, if this kind of presentation is new or different, or if the person is unknown and records/knowledgeable staff is unavailable, she/he should be medically evaluated for possible medical causes for said presentations.

Key Information to Be Elicited in *All* Assessments if at All Possible

As noted above, depending on the situation and context, there are widely variable types of mental health assessments, but in all cases, *core issues* must be addressed in *each* assessment regardless of context. Additional information can be collected or deleted depending on the clinical situation, allocated time, and consumer capacity or willingness.

Demographics

Getting a sense of the individual is imperative. Things such as age, ethnicity, marital/relationship status, employment status, and housing situation can give clues to potential sources of stressors, supports, and failures and successes that will play a useful role in figuring out what is impinging on the patient's life.

Chief Complaint

Why is this person presenting at this point in his or her life? Is the presentation voluntary (routine med check), volitional (calling the taxi for a ride to the ED), mandated (disability determination or court-ordered), emergent (brought in by ambulance unconscious after an alleged overdose) or forced (brought by police after being caught breaking windows because of acute paranoia). A good way to ask this question and to make it present-focused is: what brings you here *now*?

Salient Mental and Medical Health Symptoms

What are they reporting? What is observed? What information is available from collateral sources? Each interview must assess for potential risk of harm to self or others. Information regarding sensory deficits such as sight or hearing, substance use, cognitive deficits, medical history (including recent trauma), and medications is important to elicit regardless of situation.

Who Else Is There?

Finding out who brought the patient in, who cares enough to stay, who hides out in the waiting room, who bolts or does not return phone calls, or who aggressively approaches the provider to offer imperative information regarding the consumer is contextual information that is helpful to ascertain. Knowledge about existing, or nonexistent, supports will help with diagnosis, treatment, and discharge planning.

Past Psychiatric History

Knowledge of prior inpatient and outpatient psychiatric interface can be helpful in establishing level of functioning, insight and judgment, and capacity for adherence. Eliciting past successful treatment modalities, as well as treatment failures, may help guide treatment planning and enhance

the development of a therapeutic alliance. If one blithely suggests a treatment that has failed in the past, it indicates a lack of empathy or of inattention; the obverse—asking the patient what has worked, what are they willing to try—reflects concern and a willingness to work in partnership towards recovery.

Past Medical History

Ascertaining this information is imperative. Multiple medical problems, including substance use, misuse, abuse, or dependence, can be the etiology of mental health presentations, or can exacerbate patients' illnesses. Queries regarding present medications, including over-the-counter preparations, and adherence should be made, and the prescribers denoted so the treatment team can communicate with prior and present providers. Surgical procedures, allergies, and prior physical trauma can inform possible differential diagnoses for a variety of mental health presentations.

Review of Systems

Taking the time to elicit how a patient feels physically reflects one's concern for the whole patient, and may help the practitioner see more broadly how a mental health problem is touching the patient's life.

Family/Social/Developmental History

Hearing about one's upbringing and life circumstances from the patient's perspective can illustrate a more complete picture of the forces that had and have an influence on the patient. Developmental milestones, level of education and school performance, jobs held and lost, military service, arrests records, relationships gained, sustained and gone away, physical or sexual trauma, all have a bearing on the patient's mental health, and should be elicited *if possible*. Any family history of mental health problems might help explain present illness, or a patient's desire to ignore symptoms. Understanding the patient's perception of successes and failures can be crucial in establishing strengths-based, recovery-oriented, patient-centered treatment plans.

Mental Status Examination

Performing a formal mental status exam is helpful in painting a more complete picture of the patient's presentation. Serial assessments using such tools as the Beck Depression Inventory or Mini-Mental Status Exam can reflect response to treatment.

Similarly, assessing for presence of symptoms of depression, including suicidal or homicidal ideation, intent or plan, or symptoms of mania, substance abuse, anxiety, psychosis, and confusion, is important in establishing a diagnosis (or diagnoses) and viable treatment plan. If at all possible, performing a physical exam or obtaining the results of a recent physical exam with lab work is helpful in supporting or eliminating organic causes for a wide variety of mental health presentations.

This information should be garnered for a mental health assessment, regardless of clinical setting. Whether or not one is successful in getting all the information depends on the condition and capacity of the patient, the available time, the clinical setting, and if an alliance has been established that will facilitate a person's willingness to reveal his or her inner life. The ability to garner information and establish an alliance may also be shaped by cultural considerations of the patient and the provider.

Cultural Attributes

Chapter 15 incorporates many of the considerations regarding how cultural attributes can impact patients with mental illness, but a brief review is necessary, especially focusing on context-specific assessments. Cultural predicates

such as race, ethnicity, socioeconomic status, language, religion, customs, age, gender role, sexual orientation, sensory abilities (vision, hearing), perceived hierarchies in relationships, and levels of comfort (or discomfort) with physical boundary flexibility, can all play a role in the context of an assessment. Congruence between examiner and consumer can be helpful, but is not always easy to coordinate. "The greater the cultural differences existing between the provider and the consumer of mental health care, including socioeconomics, gender, ethnicity, language and world views, the greater is the likelihood of misdiagnosis, inappropriate care or noncompliance with treatment" (Lindsey and Cuellar 2000, p. 199). A wide variety of culturally driven coping styles and ways of communicating about illness have been observed, and the untrained, uninformed, or unempathic provider might sabotage effective assessments by ignorance of cultural differences (Alegria et al. 2008). In addition, cultures vary vastly in the degree of stigma attached to mental illness, which can then impact on how the illness is perceived and understood (Nakash et al. 2010). This may affect how often different populations access mental health care, and how accepting they will be of diagnostic and treatment regimens. The Surgeon General's report (1999) endorses the use of culturally competent services that "incorporate respect for and understanding of ethnic and racial symptoms, as well as their histories, traditions, beliefs, and value systems." Working to increase communication, empathy, appreciation, insight and comprehension for both the patient *and* the provider, can but only help in culturally competent driven assessment. Efforts to broaden understanding might ease levels of discomfort, and encourage consumer engagement. Ruiz and Primm's text on *Disparities in Psychiatric Care* (2010) is replete with examples of the impact of cultural considerations on presentation and evaluation of mental illness; in this book Nakash et al. (2010) have a brilliant chapter on the culturally sensitive evaluation that is a must-read for anyone who conducts psychiatric assessments with culturally diverse populations.

Conclusion

To embrace context-specific assessments in community psychiatry merits thoughtful consideration of many factors. While there are standard expectations of what information is necessary for any mental health assessment to be complete, the clinical status of a patient may interact with variable capacities of systems of care and unskilled providers, resulting in less than superior results. The ambience of a clinical setting can have a profound influence on how patients perceive their evaluation; maintaining a safe, welcoming contextual setting can make assessments more effective at gathering information and establishing therapeutic alliances. Training staff to identify their cultural attributes, and those of patients, may work to mitigate stigma and confusion, and to enhance understanding of mental health issues, allowing the provider and patient more effective communication and the opportunity in engage in a healing partnership.

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17 Motivational Interviewing

Igor Koutsenok

Introduction

Since the last century, we have been witnessing remarkable medical discoveries and advances in treatment, prevention, and control of many diseases and medical conditions that until recently have been considered fatal—some infectious diseases, injuries, heart and other organ failures, and many others. It is important to mention that effective treatment strategies for most of the conditions that make people seek medical consultation, such as hypertension, obesity, diabetes, anxiety, depression, drug and alcohol abuse or dependence, and many others, include a variety of necessary behavioral changes in addition to medications or other therapeutic interventions. In many instances, a healthy behavioral change is the key to a sustainable recovery, and often a behavioral change alone could be enough for a dramatic improvement to occur. Though a patient may have been genetically predisposed to develop the illness and may have been raised in an environment that contained known risk factors, it remains a fact that this individual's behavioral choices played a prominent role in the onset and course of the disorder, as well as in a possible recovery.

In fact, there are many illnesses where behavioral choices contribute significantly to initiate and sustain a disease process—especially when these voluntary behaviors interact with genetic and cultural factors. For example, there is clear evidence, at least among males, that "salt sensitivity" is genetically transmitted (heritability estimate is 0.74) (Mitchell et al. 1996; Svetkey et al. 1996) and salt sensitivity is a known risk factor for the eventual development of at least one form of hypertension. However, not all of those who inherit salt sensitivity go on to develop hypertension. This is because the use of salt is much more likely to be determined by familial salt use patterns, cultural factors and individual choice. Similarly, factors such as obesity, stress level, and exercise are the joint product of familial, cultural, environmental, and personal choice factors (Gynther et al. 1995; Kendler et al. 1992). Thus, while a diabetic, hypertensive, or asthmatic patient may have been genetically predisposed to develop a disorder and may have been raised in an environment that contained known risk factors such as poor parenting, poor diet, smoking, and high stress, it is also true that behavioral choices, such as the ingestion of high sugar and/or high cholesterol foods, smoking, and failure to exercise, also played a role in the onset and severity of their disorder.

The same set of factors that are largely under behavioral control are in fact critically important for a long-term recovery and/or effective illness

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management. In fact, health care practitioners, including professionals in the community psychiatry field, are involved in conversations with patients about necessary behavioral changes toward better health on a daily basis. This chapter presents a brief overview of a specific form of counseling known as Motivational Interviewing, which has been found effective in assisting clients and patients in their process of change toward healthier and more functional behavior.

What Is Motivational Interviewing?

Miller and Rollnik's definition of MI is "a client-centered directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller and Rollnick 2002). Motivational Interviewing (MI) is an empirically supported intervention and a well-recognized counseling style that has been widely disseminated and implemented in a variety of physical and behavioral health practices. This communication style is both a philosophy and a broad collection of tools and techniques to help clients resolve their hesitations about possible behavioral change and find their own reasons for change (Miller and Rollnick 2002). MI draws heavily on Rogers's personality theory (Rogers 1951) and the notion that psychopathology reflects a discrepancy between one's perceived or experienced self and his or her ideal or valued self. MI also adopts the client-centered value of the therapeutic relationship as a primary change agent through multiple factors, including, most prominently, therapist empathy.

Motivational Interviewing provides additional support to client-centered principles generally, as well as to the centrality of therapist empathy as one of the key treatment factors. One of the basic MI assumptions is that people change their behavior with varying levels of readiness, and the role of helping professionals is to assist patients in making choices and in their understanding of the results of both "change" or "no-change." This could be accomplished through a nonjudgmental interview process that involves strategic use of questions and statements. A core belief of MI is that effective behavioral interventions are collaborative in nature and defined by the relationship and rapport between the professional and the client. Motivation in general is very dynamic, fluid, and constantly changing, and the directions of the change are mostly defined by the client–practitioner interaction (Moyers et al. 2005).

It is important to recognize that no patient is completely motivated or unmotivated for change. MI works from the assumption that many clients who seek treatment are ambivalent about change and that motivation will fluctuate during the course of therapy. Therapists therefore should be aware of such variations, working with them rather than against them. Ambivalence (i.e., contradictory thoughts about change—"should I or shouldn't I") is completely normal and is always present to various degrees even with the slightest and safest changes that you can think of. One of the expressions of the ambivalence is the impulse for homeostasis, or a desire to keep things the same. A simple illustration of that would be if we ask the reader to put their watch on the wrist of the hand opposite from where they usually wear it. Most of you will feel certain discomfort and an almost immediate impulse to put it back (homeostasis). Change is tough; we all have mixed feelings and thoughts about it, and this hesitation is not a problem. Instead, this is a critical part of the process and something that gives us a lot of material to work through with the client to assist him/her to resolve. For helping professionals, it is also important to accept that there is a constant dialectical "change-no change" struggle in patients, leading to periodic setbacks and even possible returns to old behaviors. In other words, the process of change is not linear and goes through successes and steps back, and this "back and forth" dynamic is normal as well (Arkowitz 2002).

In health care settings, including community psychiatry, the range of possible health behavioral changes with patients is considerable—medication compliance, weight control, fluid intake, healthy diet and exercise, smoking, drinking, drug use, job finding, safe housing arrangements, and multiple others. The way practitioners discuss these issues with patients can have a significant influence on their initiation and

maintenance of healthy behavioral changes (Hettema et al. 2005; Moyers et al. 2007), and MI provides a conceptual framework, style, spirit, and tools for such conversations.

Efficacy of MI

The efficacy of MI has been evaluated in multiple studies, randomized clinical trials, and meta-analytical research in a large variety of settings and in multiple populations. Since publication of the first edition of the motivational interviewing book (Miller and Rollnick 1991) more than 100 randomized clinical trials of MI, considered the gold standard in studying treatment efficacy, have been published. In the past decade, three exemplary studies have provided strong support for the efficacy of these approaches in the areas of substance use disorders (Miller et al. 1993; Project MATCH Research Group 1997; Stephens et al. 2000). MI has been used and carefully studied in the treatment of various other life problems, psychological and physical conditions and shows that approximately 75% of those studied do obtain an effect, which is supported by the meta-analysis (Rubak et al. 2005).

It appears that MI is not limited in any way to counseling of clients with drug and alcohol problems, but can be used in the treatment of a broader area of conditions, in which healthy behavior changes are essential part of the recovery process. Several studies have shown no effect of MI in patients with certain types of conditions (Miller et al. 2003; Baker et al. 2006), as well as variations in effectiveness across different cultures (Hettema et al. 2005; Villanueva et al. 2007). However, one of the important findings is that there are no apparent harmful or adverse effects of MI, which suggests that this is a method with an important potential effect, from which patients very well may benefit. In general, there is strong evidence that MI can be effective in promoting behavioral change in a variety of conditions, even though there are variations in MI efficacy depending on the type of behavioral problems, cultural context, staff training, patients' attributes, and other factors.

Spirit of Motivational Interviewing

MI is more than just a counseling style or a number of techniques. In large measure, MI is a way of interacting, a way of being with people. A significant correlation between the interpersonal skills of helping practitioners and clients' engagement in the change (treatment) process has been established in previous studies (Boardman et al. 2006). Thinking about and understanding of others are integral and crucial components of effective interviewing, and they are described by Miller and Rollnick (2002) in the context of the spirit of MI. Motivational Interviewing is a collaborative process between a patient and a professional. This interaction is based on partnership rather than the more traditional roles of the professional being the expert and the patient being the recipient of the expertise—an interaction that is common in most traditional health settings. From the partnership perspective, counselors avoid argumentation or persuasion with clients, thus the whole interaction is based on exploration of the clients' viewpoints rather than instilling the counselors' ideas about what is the best course of action for the client. Therefore, MI is a truly client-centered approach.

Consistent with the collaborative nature of MI, the counselor is trying to evoke the client's ideas about the nature of the problem, possible ways toward more functional behavioral changes, client's hesitations, and ambivalence about making or not making any change. Therefore, evocation is another key component of the MI spirit. The ultimate responsibility of making or not making any change is with the client. At the end of the day this is his/her life and they are the only experts and owners of it. Even if the counselor's belief, based on his/her training and experience, is that the choice the client is making is not the best for the client, we still respect the clients' autonomy to make those choices without imposing our own goals and values on them. In general, the spirit of MI is just the opposite of the more traditional counseling style in which the counseling process involves direct confrontation, education, or telling the client what to do from the authoritarian position of being a counselor or

expert. The MI spirit of collaboration, evocation and respect for autonomy is crucial to MI, but in addition to the spirit, there are specific principles and methods.

Principles of Motivational Interviewing

The four basic principles of MI (Miller and Rollnick 2002) are express empathy, develop discrepancy, roll with resistance, and support self-efficacy.

Express Empathy

Empathy is the counselor's ability to understand the sources of and reasons for client's perspective, emotions, thoughts, and actions. Empathy also involves an effort to draw out concerns and reasons for change from the client, instead of relying on the practitioner's agenda as the sole persuasion strategy. The ability to understand the client's feelings and hesitations in general is critically important for any client-centered counseling style (Rogers 1951). The principal way to do it is by being very interested in patients' lives and hearing their own reasons for change, or not to change, their desires of what they want in life, their own ideas about how they could go about it. Through reflective listening, the counselor tries to understand the client's feelings and ideas without criticizing, judging, or arguing. It is important to emphasize that understanding is not equal to agreement or approval. Ambivalence toward behavioral change is accepted by the counselor as normal human behavior rather than a symptom or sign of any pathology or denial.

Develop Discrepancy

The easiest way to think about MI is that it assists people to make a decision to change. People change when they decide they are ready to change, or at least understand that this is the right thing to do, even though a part of them does not want to do it. Even when patients do not explicitly talk about their hesitations, the internal dialog is still ongoing, at least privately, in their minds, and the MI helps to bring this conversation to the surface, discuss it openly, and help the person move alone toward decision-making. Instead of the professional taking responsibility for the patient's change, telling them how important it is, how they could accomplish it, and why it is important for them to want to do it, it is critical to hear their own rationale, hesitations, and discrepancies. This is why helping professionals pay particular attention to the patient's argument in favor of change, as well as their argument in favor of not changing anything, and then differentially elicit and explore the ambivalence to change.

Roll with Resistance

Resistance to change is a normal human behavior. It illuminates patients' desires and fears, and multiple expressions of resistance are valuable sources of information about the dynamics in the client–counselor interaction. Resistance is not a psychological trait of anyone, neither is it a symptom of any pathology. A helpful way to look at patient resistance is to accept it as their ambivalence put under pressure. This is one of the critical components in learning and implementing MI in clinical situations: Resistance is a result of interaction between two or more people, and increased resistance is a good sign to the therapist that he/she need to change the strategy. The therapist's impulse to take the side of the "good side" of the ambivalence ("change talk") is understandable. However, this could be a profound experience to the client to find the therapist listening to their argument against behavioral change (counterargument, or "sustain talk") empathetically and compassionately without pushing them to make the change. That is how the ambivalence gets resolved. If a practitioner uses his/her power as the "expert" to make them change, the patients will immediately favor homeostasis, i.e., no change, and this is likely to become a power struggle rather than effective counseling.

Support Self-Efficacy

It has been noted that the client's outcomes are typically better if the client is actively engaged in the treatment process (Rollnick et al. 2008). In order to engage patients and maintain their level of active participation, it is important to support their belief that they are actually capable of making the change, and if they decide to do so, they may have a number of good ideas about how it can be done. Without this belief, a combination of awareness of the problem and inability to find a solution will trigger defensiveness and resistance to change. In fact, at least in addiction treatment, this treatment roadblock is well known and often referred to as the "learned hopelessness" phenomenon. From the MI standpoint, the belief is that most people do have necessary knowledge and resources to make desired change, and could come up with good solutions if provided the opportunity to verbalize them.

Motivational Interviewing Skills

Perhaps the first question that clinicians need to be clear about is what is the target behavior—a specific behavior that the client is ambivalent about changing? The practitioner will move the client in the direction of that change by the strategic use of MI skills. Consistent with the spirit of MI and its foundational principles, there is a set of skills that clinicians need to develop in order to use MI effectively. Most of them come directly from the Rogerian client-centered psychotherapy, such as asking open-ended questions, reflective listening, affirmations and summaries (OARS). These tools are used most intensely during the first phase of MI, when the client is ambivalent about change and motivation is very fluctuating. The primary reason for using these tools is to assist patients in resolving their ambivalence and increasing the intrinsic motivation for change. Clinicians use OARS skills strategically to strengthen client change talk. The strength and frequency of the client's change talk is evidenced by client's talking more about possible change, reasons for it, the future that includes the desired change, and possible ways to make it happen. In that case, another additional skill commonly referred to as "eliciting change talk" becomes critically important in navigating clients through their ambivalence and directing them toward change. During the second phase, the focus shifts to strengthening the commitment to change and assisting clients in formulation and implementation of a plan.

Open-Ended Questions

In general, questioning is not a part of good listening and is typically a roadblock in counseling (Gordon 1970). It is very important to make sure that the client is doing most of the talking, the client's agenda is carefully listened to, and open-ended questions are used to achieve this goal. Open-ended questions allow the clients to come up with a narrative rather than with "Yes" or "No" answers or very short answers. At the same time, I do not want to create an impression in the reader, that open-ended questions are "good," and closed-ended questions are "bad." This would not be true, because we need both types of questions. They just serve different purposes. Closed ended-questions aim at fact finding, while open-ended questions aim mostly at rapport building. By asking more open-ended questions clinicians can focus the client on the areas that seem to be important in exploring ambivalence. Additionally, open-ended questions are very helpful in establishing an atmosphere of trust and acceptance with the clients, which is particularly important at early stages of the relationship building. Examples of open-ended questions are "What would you like from treatment,?" "Tell me more about your drinking," and "If you were to quit, how would you do it?"

Affirmations

Affirmations are statements with which clinicians share their appreciation and acknowledgments of the client's struggles, difficulties, successes,

skills, strengths, goals, and values. Affirmations are helpful in empowering and supporting the client's movements toward desired change. Affirmations may include comments on the client's positive behavior ("You are a strong person, a survivor"); a statement of appreciation ("I appreciate your openness and honesty today"); a compliment ("I like the way you said that"). Other examples of affirmative statements are "It takes courage to face such difficult problems," "This is hard work you're doing," "You really care a lot about your family." There are suggestions that the optimal ratio for positive behavior change is about four affirmations for every critical comment (Cullen 2002). A less rigid rule of thumb is to use as many affirmations as possible and affirm any positive behavior that practitioners want to see repeated and sustained.

Reflections

Reflective listening is the core MI skill and perhaps the single most important and most challenging in learning and implementing this counseling style. In fact, using reflections during the interview gives us much more information than asking a whole lot of questions. Reflective listening has its roots the fields of counseling and psychotherapy, particularly in Carl Rogers's "client-centered" therapy (Rogers 1951). In reflective listening, the listener adopts what Rogers called "the therapist's hypothesis." This is the belief that the capacity for problem solving and change toward desired behavior resides primarily in the client. This means thatthe central questions for the practitioner are not "What can I do for this person?," or even "How do I see this person" but rather "How does this person see himself or herself, and what is his/her view of the situation?" Reflections serve as a bridge between the client and the practitioner. By using reflection, the practitioner tries to clarify and restate what the client is saying. Reflections increase the practitioner's understanding of the client's point of view; they help the client to clarify his/her thoughts; and they reassure the client that the practitioner is listening and wants to help. The main principles of reflective listening are:

1. Do more listening than talking.
2. Restate and clarify what the client has said, instead of asking questions or telling what the listener feels, believes, or wants.
3. Try to understand the feelings contained in what the other is saying, not just the facts or ideas.
4. Develop the best possible understanding of the client's frame of reference and avoid the temptation to respond from the listener's frame of reference.
5. Empathize and send a clear message of acceptance, even if you disagree with the client's choices or behavior.

Examples of Different Types of Reflections[1]

Simple Reflection

One way to reduce resistance is simply to repeat or rephrase what the client has said. This communicates that you have heard the person and that it is not your intention to get into an argument with the person.

Client: But I can't quit drinking. I mean, all of my friends drink!

Counselor: It seems nearly impossible for you to quit drinking because you spend so much time with others who drink.

Client: Right, although maybe I should.

Amplified Reflection

The counselor amplifies or exaggerates the client's statement by adding a new meaning to it.

Client: I can't quit using because all of my friends use!

Counselor: Oh, I see. So you really couldn't quit using because then you'd be too different to fit in with your friends.

[1]Material adapted from Ingersoll et al. (2000); NIAAA Project MATCH motivational enhancement therapy manual (Miller et al. 1992; Rosengren and Wagner 2001); published on http://www.motivationalinterview.org/clinical/interaction.html.

Client: Well, that would make me different from them, although they might not really care as long as I didn't try to get them to quit.

Double-Sided Reflection

With a double-sided reflection, the counselor reflects both the current resistant statement, and a previous, contradictory statement that the client has made.

Client: But I can't quit drinking. I mean, all of my friends drink!

Counselor: You can't imagine how you could not drink with your friends, and at the same time you're worried about how it's affecting you.

Client: Yes. I guess I have mixed feelings.

Shifting Focus

Another way to reduce resistance is simply to shift topics. It is often not motivational to address resistant or countermotivational statements, and counseling goals are better achieved by simply not responding to the resistant statement.

Client: But I can't quit drinking. I mean, all of my friends drink!

Counselor: You're getting way ahead of things here. I'm not talking about your quitting drinking here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing here—talking through the issues—and later on we can worry about what, if anything, you want to do about it.

Client: Well I just wanted you to know.

Rolling with Resistance

Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often will bring the client back to a balanced or opposite perspective. This strategy can be particularly useful with clients who present in a highly oppositional manner and who seem to reject every idea or suggestion.

Client: But I cannot quit using. I mean all of my friends use!

Counselor: And it may very well be that when we're through, you'll decide that it's worth it to keep on drinking as you have been. It may be too difficult to make a change. That will be up to you.

Client: Okay.

Reframing

Reframing is a strategy in which you invite clients to examine their perceptions in a new light or a reorganized form. In this way, new meaning is given to what has been said. For example, if a client reports a spouse or loved one as saying, "You really need to get in treatment and deal with these problems," the client may view this as "she's such a nag" or "he is always telling me what to do." The counselor can reframe this as "this person must care a lot about you to tell you something he (or she) feels is important to you, knowing that you will likely get angry with him (or her)."

Reframing can also be used to discuss the issue of tolerance. Clients may report that they are especially good at holding their liquor, or may view their substance use as nonproblematic because they do not "even really get high anymore." This gives the counselor the opportunity to discuss notions about tolerance, and reframe it to the client as not having a built-in warning system to indicate when he or she has "had enough." Thus, what originally appears to support the concept that there is no problem ("I can hold it") now supports the concept that there may be a problem ("I'm at risk for overdoing it without knowing it until it's too late").

Summaries

Summarization is another important skill in MI. It helps by organizing the material that the client offered during the session ("So far you have expressed your concerns about your children, your financial situation, and finding a safer place to live"). Summaries also help in linking the information from previous sessions with the newly shared information ("That sounds a lot like what you told me 2 weeks ago about changes in your mood and anxiety level"). They may serve as a transition from a task that has already been discussed and accomplished to a new task ("During the last several sessions we talked about your desire to

find a job and you have just accomplished it. You also mentioned your desire to get your children back. Please tell me more…").

Eliciting Change Talk

We use the above-mentioned skills to elicit and strengthen everything that the clients says in favor of desired behavioral change, or so called "change talk," as opposed to the "sustain talk" (everything in the clients' speech in favor of not changing). Both change and sustain talk are always present with various degrees of strength, and the practitioner's task is to listen very carefully and use MI skills to respond in a way that will make the change talk stronger and possibly lead to some form of commitment to change. The ultimate goal is to support the client's commitment by skillful recognition and strengthening the change talk. This is very important because the probability of positive behavioral change (i.e., desired outcome) is directly related to the client's change talk and inversely related to sustain talk (Miller and Rose 2009). Change talk consists of a variety of statements reflecting desire for change, ability to make those changes, perceived reasons or need for change, as well as readiness for or commitment to change. In drug and alcohol treatment, statements reflecting change talk, particularly commitment to change, have been found to be the strongest predictor of positive treatment outcomes (Amrhein et al. 2003). Strengthening the client's commitment and developing a change plan are the core components of MI. Miller and Rollnick (2002) describe indicators that suggest that the client is moving toward desirable change, such as decreased resistance to change, less time spent on discussing the problem and more time spent on possible solutions, increased change talk, more frequent questions about possible change, a better picture of the future that includes the change, and some initial experimentation with possible change actions between meetings. It is important to note that behavioral change is not a linear process; motivation for change is very dynamic and fluctuating, ambivalence is always present to greater or lesser degree, and some setbacks are likely to occur.

MI in Clinical Mental Health Practices

Fluctuating adherence to necessary treatment is often related to high levels of ambivalence about change in many mental health patients. For example, up to two-thirds of individuals entering treatment for mental health problems are significantly ambivalent about change (Dozois et al. 2004). Premature terminations from mental health treatment and treatment noncompliance are common in virtually all modalities of treatment and present a significant impediment to the delivery of services (Walitzer et al. 1999). Therefore, the use of MI as a strategy that addresses ambivalence to change either as a "stand-alone" intervention or in conjunction with other treatment modalities does make a great deal of clinical sense. Combining MI with cognitive behavioral therapy (CBT) has resulted in considerable improvements in patients treated for anxiety disorders and depression (Arkowitz and Westra 2004; Westen and Morrison 2001). Treatments that incorporate MI have been used successfully with patients with substance use disorders comorbid with social anxiety disorder (Buckner et al. 2008), particularly when MI was added to CBT for patients who did not respond well to CBT alone (Westra 2004).

MI may be particularly promising as a preparation for treatment, or a preparatory intervention with the goal of increasing motivation and resolving ambivalence about change and participation in the treatment process. Although research in the area of psychotherapy pretreatment is limited, existing data suggest that such treatment preparation improves treatment attendance (Walitzer et al. 1999). The addition of brief MI intervention prior to other treatments can be particularly helpful in the substance use domain (Burke et al. 2003) even when subsequent treatments are based on models and techniques other than MI. Use of MI has been found helpful not just as a preparation for other types of psychotherapy but also during treatment to address emerging ambivalence, hesitations, and resistance to change (Arkowitz and Westra 2005). In general, MI can be used as a "stand-alone" treatment or in conjunction with

other treatment modalities. In fact, a trained therapist will use MI strategies at any point during therapy when motivation is fluctuating and a greater degree of ambivalence is encountered, regardless of the treatment modality.

Summary

Motivational Interviewing is an evidence-based psychotherapeutic method that can be a very helpful addition to any mental health service due to its applicability across a wide variety of problem areas and great compatibility with other treatment approaches. Since the beginning of its development, MI has already made significant impact on treatment delivery in general mental health, addiction treatment field, and many other behavioral conditions. With new research on the underlying mechanisms of MI, we will be able to enhance its use and assist practitioners in implementing MI in their daily clinical operations.

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Team-Based Treatment

18

Carl C. Bell, Dominica F. McBride,
Juanita Redd, and Hayward Suggs

Introduction

> Teamwork is the ability to work together toward a common vision. The ability to direct individual accomplishments toward organizational objectives. It is the fuel that allows common people to attain uncommon results.
>
> —Andrew Carnegie

Many have recognized the power of teams in various arenas. A sports team is a prime example where interdependence is apparent. For example, in a football team, each position has a set of skills and a knowledge base that accompanies it. Each position must depend and rely on the skills and knowledge base of the other positions in order to accomplish their collective goal successfully. This outlook can inform all teams, especially interdisciplinary administrative and clinical mental health teams, despite their complexity. Because of the strength of this model, this chapter focuses on team-based treatment in mental health. It places particular emphasis on a pertinent structure of community mental health centers (CMHCs) (composed of administrative and clinical teams), the importance of multidisciplinary treatment teams in this context, the problems that multidisciplinary treatment teams often face, and possible solutions for teams to function effectively.

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A Model of Community Behavioral Health Services

This chapter is based on community psychiatry work and professional, team-based experiences at the Community Mental Health Council, Inc., a multimillion-dollar, not-for-profit, comprehensive CMHC located on Chicago's Southside that serves a predominately African-American, underserved community. This organization was built upon a model of community psychiatry with various components added to meet the local community needs (see Fig. 18.1). A comprehensive CMHC should have a responsibility to provide localized treatment (i.e., located in the target community) and be governed by a community board of directors from the population being served. A comprehensive CMHC should also provide comprehensive services as defined by the

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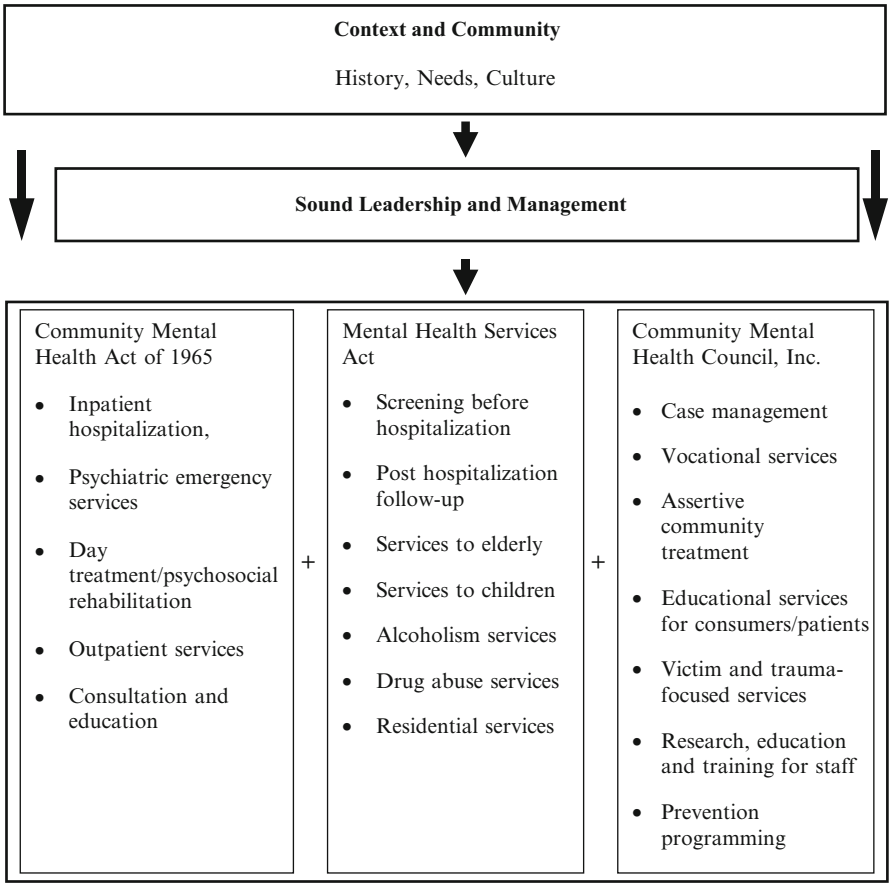

Fig. 18.1 Community mental health council comprehensive model for CMHC

Community Mental Health Centers Act in 1963 (Public Law 88-164), which includes the following: (1) inpatient hospitalization, (2) psychiatric emergency services, (3) day treatment/psychosocial rehabilitation, (4) outpatient services, and (5) health and mental health consultation and education focused on prevention (Cutler et al. 2003). The 1980 Mental Health Services Act (Public Law 96-398), which required (1) screening before hospitalization, (2) posthospitalization follow-up, (3) services to elderly, (4) services to children, (5) alcoholism services, (6) drug abuse services, and (7) residential services, should also inform it (Cutler et al. 2003).

In over three decades of mental health experience, Community Mental Health Council, Inc. has determined that comprehensiveness in this field requires additional service provision. These services include the following: (1) case management—designed to weave fragmented services together (Ziguras and Stuart 2000), (2) vocational services—designed to give consumers/patients an opportunity for meaningful work, (3) assertive community treatment—characterized by comprehensive and extensive outreach and advocacy (Dixon 2000), (4) educational services for consumers/patients that ensures they have access to the best, most current and appropriate technology (biotechnical and psychosocial), (5) victim and trauma-focused services—designed to minimize a major driver of unhealthy behaviors (Bell 1991), (6) prevention and wellness services—designed to encourage recovery, resilience and healthy growth or "flourishing" (Keyes 2007), and (7) research, education, and training for staff that maximizes opportunities to move science

to service. Sound leadership and management should guide this combination.

Community Engagement and Prevention

If this array of services and the CMHC functioning does not include community guidance, the CMHC would fail to sufficiently connect to the community and properly meet their needs. Therefore, as stated above, a comprehensive CMHC should emphasize consumer/patient participation and be governed by a community board of directors. In conscientiously responding to the various community needs, a major role of such an organization is to provide consultation and education to facilitate implementation of prevention and health promotion. Prevention consists of: *universal interventions*, which address the population at large; *selective interventions*, which target groups or individuals with an elevated risk; and *indicated interventions*, which target individuals with early symptoms or behaviors that are precursors for disorder but are not yet diagnosable (National Research Council and Institute of Medicine 2009). These strategies are further subcategorized as either biotechnical (e.g., inclusion of dietary Omega-3 for brain development, Embry 2011) or psychosocial (e.g., multiple family groups for teaching parenting, Pinto et al. 2007) prevention techniques. Such prevention and health promotion should be accomplished by providing mental health consultation to various governmental and nongovernmental providers of mental health services and assisting in community development and consumer/patient education. In an effort to avoid unnecessary morbidity and mortality, a comprehensive CMHC must also either provide physical health care or have strong linkages to a physical health care system, and ideally should have strong linkages to systems that emphasize recovery and flourishing (Keyes 2007). These efforts require constant assessment and evaluation of the needs of the community served.

It is vital, as the organization is growing, to ensure that its contributing members have the opportunity to grow as well. Therefore, in becoming a responsive, inclusive, and comprehensive CMHC, formal education based on sound research for both its consumers/patients and staff needs to be provided. Thus, formal partnerships with academic institutions providing education and research are essential in creating a learning organization (Senge 1990) where professional development is encouraged. This approach enhances the organization's potential for delivering evidence-based, culturally sensitive interventions developed specifically for an underserved population. Further, education based on sound community-based research, and conducting sound research in and of itself, contributes to the desperately needed knowledge base of diverse populations (Department of Health and Human Services 2001). This community-based research on mental health issues makes academic institutions more responsive to realities within diverse communities, and it helps to make CMHC staff and consumers/patients more responsive to learning and research on issues directly related to their specific needs. Finally, leadership and internal operations or administration are integral to the success of CMHCs. If a CMHC does not have smoothly functioning administration, it will not be equipped to meet the needs of the community comprehensively and appropriately.

A comprehensive CMHC should also provide continuity of care either by seeking to provide a seamless array of the above comprehensive services via a consortium model (i.e., the comprehensive services are delivered through multiple different agencies with legal arrangements between that unites them as one comprehensive system) or by an umbrella model (i.e., all the services are delivered by one system).

The Value and Pitfalls of Multidisciplinary Teams in a CMHC Context

It is only through a multidisciplinary approach encompassing disciplines like Biostatistics, Business and Public Administration, Criminal Justice, Medicine, Nursing, Psychiatry, Psychology, Public Health, Psychiatry, Psychology, and Social Work

that a CMHC can accomplish its mission. A multidisciplinary team is necessary to deliver the complex array of services needed—diagnostic services, prescribing medications, housing, securing benefits, teaching skills of daily living, teaching vocational skills, facilitating social interactions, conducting research, crisis and emergency work, hospitalization, psychosocial rehabilitation, care of physical illness, education, management, and leadership. A multidisciplinary team approach allows the transition from an individual and illness focused conception of treatment to a broader view including the public health and prevention approach to services. Even though this shift may require a significant change in organizational culture and capacity, the benefits are not only supportive but also transformative.

There are multiple models for running CMHCs. There is no right or wrong model as the success of an organization depends on multiple human factors involved in the work. Regardless of the objectives of the team (i.e., a business or a clinical team), it is our impression that persons trained in business, leadership, and management are best equipped for cultivating a healthy multidisciplinary team.

The source of strength of multidisciplinary teams is also its source of weakness—diversity. While the diversity of multidisciplinary teams has its advantages in being able to have expertise in multiple domains, the difference in perspective of each professional and consumer/patient creates a tremendous potential for conflict in professional relationships. Covey (1989) points out the most valuable human resources are relationships. Weak relationships result in poor communication, disagreements, negative feelings (i.e., jealousy), and negative behaviors (i.e., backbiting and criticism). Unfortunately, work environments characterized by professional conflict and weak relationships drain time and energy that would be better used for personal growth and organizational success. Thus, the conflict potentially inherent in multidisciplinary teams, whether they are clinical, research, educational, or business office teams, needs to be managed. The ability for a team to self-correct is essential for strong functioning. Part of self-correction is identifying behavior, skill or attitudinal issues that influence outcomes.

Dysfunctional and Functional Aspects of Multidisciplinary Treatment Teams

While multidisciplinary treatment teams ostensibly have a wealth of information about a consumer/patient or family, the major barrier to obtaining good clinical outcomes is a failure to implement that knowledge and work together as a team. With leadership being an integral part of the functioning of a team, there are many potential obstacles that can prevent effective treatment teamwork. Each of the barriers discussed in this section relate to treatment teamwork. Lencioni (2002) highlighted five major dysfunctions of a team: (1) absence of trust, (2) fear of conflict, (3) a lack of commitment, (4) avoidance of accountability, and (5) inattention to results.

Absence of Trust

The *absence of trust* derives from insecurity and fear of vulnerability on various levels—from treatment team leadership to membership. Sometimes leadership feels threatened or weak and, as a result, is not open with treatment team members about their weaknesses. This kind of omission obstructs the path to building a strong foundation for trust. Multidisciplinary treatment team members who lack trust often hide their limitations and mistakes from the treatment team and are scared to ask for help or to admit their lack of knowledge or skill. For example, if a consumer/patient's primary therapist on the treatment team is fearful of the consumer/patient and scared to admit this fear to their colleagues, the consumer's/patient's treatment will be less than optimal. Distrusting treatment team members can also make negative assumptions about other team members actions or intentions, participate in rumors, and either derail or fail to participate in the work toward the common mission of improving consumer/patient outcomes. As a result, members who lack trust have no true ownership of the treatment team or its mission.

Conversely, trusting treatment team members are able to admit their shortcomings, and, if need be, ask for help. They tend not to be defensive when questioned about their area of responsibility and do not make assumptions about other team members' lack of competence. This type of member feels safe in giving and taking feedback and helping others with their work. They focus on the mission of the treatment team to improve consumer/patient outcomes, and work toward accomplishing it through collaboration instead of focusing on trite, interpersonal challenges.

Covey (1990) stated that trust is based on two elements—character and competence. A well-functioning treatment team has to have the willingness, ability, and opportunity to address trust issues that influence its performance or it is doomed to fail. When trust is low, no amount of communication will suffice. "Personal mastery" (Senge et al. 1994) must include the ability to share one's insights about team functions and behaviors in a way that is acceptable. Covey (1989) talks about this as having the courage to say what needs to be said, and the sensitivity to say it in a way that is acceptable to the recipient. As professionals, who use these communication skills with consumers/patients, it would seem these skills would be easily transferable to the treatment team process. Balancing courage and consideration with respect for the benefits of team conflict allows the treatment team to problem solve in an open and straightforward manner.

Good leadership can effectively address the problem of distrust in multidisciplinary treatment teams. These leaders understand and model excelling without competing, and they understand no one else has to lose for them to win. Consistently manifesting these values generates trust within the treatment team. Exemplary multidisciplinary team leaders also recognize and honor the contribution and uniqueness of the skill set of each team member and display gratitude for genuine effort and acts of interpersonal kindness within the team. Leaders who are able to build trust on teams recognize and learn from mistakes. They trust others, are curious, listen to others, and are open to other people and their ideas. They also are willing to show their vulnerability. While being vulnerable often evokes fear, the display can have potent effects. By displaying vulnerability as a leader, other team members often follow suit and present a willingness to be open and grow.

Fear of Conflict

Lencioni (2002) went further and conveyed that the failure to build trust is related to the genesis of the second multidisciplinary treatment team dysfunction—the *fear of conflict.* The underlying tension that develops from a lack of genuine communication is conducive to the generation of conflict. Covey (1990, p. 45) appropriately notes, "The root cause of almost all people problems is the basic communication problem—people do not listen with empathy"; thus, his counsel to "Seek First to Understand, Then to Be Understood." This conflict generated from poor treatment team communication is often expressed outside of team meetings (e.g., in private conversations) and frequently divides the team into contentious factions that sabotage the treatment team's work and agreed upon mission. Teams that are scared of conflict have ineffective meetings; and create a culture of gossip and "work arounds" (i.e., taking short cuts to avoid standard operating procedures). They tend to ignore the proverbial "elephants in the room" because of fear of open communication. Teams that fear conflict do not learn from the other team members and spend an inordinate amount of time and energy on self-protective behaviors.

Healthy multidisciplinary treatment teams tolerate healthy conflict, which involves effective and open communication directed at resolving problems. These teams' meetings usually include creative thinking, where everyone's ideas are considered and explored. These meetings are engaging, fun, and cultivate a sense of power as real problems are solved quickly with minimal transactional blunders. In addition, healthy multidisciplinary treatment teams focus on vital forces that shape major portions of the desired outcome rather than miniscule and insignificant issues. A healthy team embraces the value that some level of tension is important

Table 18.1 Research approach vs. the action approach from Block (2000) (reprinted with permission of John Wiley & Sons, Inc.)

Research approach	Action approach
Interested in all factors that impact the problem at hand	Interested in factors that are under the control of the client and affect the problem
Being comprehensive and complete in the discovery phase is essential	Completeness and comprehensiveness are not necessary. They can be overwhelming at the point of deciding what to do
You can do research on your own. The organization does not have to be involved as part of the research team	The client's involvement in the study is important at each stage
You try to eliminate bias and intuition of the researcher. Heavy emphasis on objectivity and hard data	Consultants are getting paid for their own bias and intuition—it is called judgment. You use all the feelings and perceptions you have in addition to hard data
Essentially neutral toward whether the organization approves of the outcomes of the study	Deeply concerned about the attitude of the client toward the outcome of the study

for growth and new ideas. In fact, healthy teams seek to air the conflict within a team as the successful negotiation of conflict increases team cohesion. A healthy treatment team has a balance between transactional leadership (e.g., hierarchical. product oriented, Covey 1990) and transformational leadership (e.g., empowering, process oriented, Covey 1990).

Sometimes, a clinical team lacks the ability to determine when their plans are "good enough" to move forward. Teams sometimes confuse perfection with success and are overly critical of their own work, to the point of struggling to be perfect. They think that there is always time for one more diagnostic code, problem focus, or reworking of a treatment plan in an attempt to "help the patient." However, this mentality can often have an opposite demoralizing effect in a treatment team environment. Weiss (2010) talks about the dangers of valuing perfection (100%) over success and how often 80% is good enough. He goes on to say that the additional 20% is very seldom warranted or even beneficial. This perfectionist style can destroy synergy in a multidisciplinary treatment team environment and severely hamper a team's ability to move from a "research" approach to an "action" approach (Block 2000). A research approach seeks to explore all factors influencing in clinical outcomes. Despite the value of this, it may actually be obstructive to the accomplishment of outcomes (Table 18.1). Alternatively, in an action approach more focus is placed on the major, weighty factors that potentially improve good consumer/patient outcomes.

Lack of Commitment

Frequently, a lack of trust and fear of conflict either indicate a *lack of commitment* to the treatment team's mission or create this lack, which is the third dysfunction described by Lencioni (2002). This lack of commitment can intrude on the team's effort to achieve their goals. If there is a lack of trust and fear of conflict, members do not put forth their ideas and, as a result, have no ownership of the multidisciplinary treatment team's mission of quality consumer/patient care or the team's strategy to accomplish this mission. Ordinarily, a multidisciplinary treatment team's mission is relatively limited, i.e., to provide consumers/patients with quality clinical care for their illness. Attempts to broaden the mission to promote wellness, for example, may fail if uncommitted treatment team members are not on board. Although they may support the addition superficially, behind closed doors they may be sabotaging the teams' efforts. Team members who are uncommitted may hinder its implementation by pushing for perfection in treatment team decision-making and outcomes before moving forward.

For a multidisciplinary treatment team to have a strong mission, solidified strategy, and synergy,

each member's opinion and ideas should be addressed, with agreements and disagreements included in the discourse, but it must be recognized that absolute consensus in not always possible. If team members feel disrespected, it is difficult to move elements of the agenda forward. This may result from autocratic team leadership. A lack of an inclusive process also prevents what Senge (1990) calls "personal mastery" and "shared vision" (two of the five essential features for having a "learning organization"). Healthy team members are able to commit to team decisions, whether they agree with them or not and, are able to honor their team's decision to move forward and respond to the challenges with curiosity instead of blame. If teams fail to make difficult decisions in the hopes that the problems simply go away or if they delay decisions until all ambiguity is resolved, it will be difficult for them to begin moving in what seems to be the right direction. This is a major difference between the research approach (obsessive, comprehensive) and the action (result oriented) approach outlined in Table 18.1.

There has to be system reinforcements that reward cooperation over competition. Covey (1989) discusses the Six Paradigms of Human Interaction with "Win–Win" being the highest and most desirable interaction. Individuals must see how to create a win for themselves without defining winning as beating the other person. A competitive focus vs. a cooperative focus yields transactional results vs. the transformational results that emanate from cooperation. While elements of both transactional and transformational leadership may be needed, a true win–win outcome requires a transformational, cooperative approach, to ensure long-term viability of team-based efforts (Covey 1990).

Although it is true that obtaining multidisciplinary treatment team buy-in to mission and strategy extends and complicates the process leading to action, the outcomes from teamwork are far better than those delivered by autocratic leadership. When multidisciplinary treatment teams are able to make a commitment, a clarity of purpose rather than politics leads the team, and it is able to effectively and efficiently progress.

Avoidance of Accountability

The fourth dysfunction Lencioni (2002) identified is an *avoidance of accountability*. In their efforts to encourage trust, too often multidisciplinary treatment team leaders "expect what they do not inspect." Leaders can succumb to expecting outcomes without evaluating and consistently assessing the process of reaching those objectives. Being mission-driven gives everyone on the team the power to ask each other "How is this conversation helping us achieve quality consumer/patient care and wellness?" This is a gentle way of questioning without being threatening or confrontational and risking ruining relationships. One caveat is that treatment teams that develop a great deal of trust, cohesion, and closeness run the risk of avoiding issues of accountability squarely and also may avoid confrontation of conflict because they do not want to disrupt the "functional family" feeling such a healthy team creates. Multidisciplinary treatment team members who have high standards and who are clear about their values and mission are the most likely to hold each other accountable.

Lencioni (2002) asserts that a lack of accountability produces resentment among team members who may have different standards of performance. It encourages mediocrity, and results in missed deadlines and deliverables with the enforcement of accountability falling to the leadership. Good leadership instills a culture of mutual accountability in all the clinical and support team members (e.g., the manner the receptionist welcomes a consumer/patient for their appointment can have a significant influence on the therapy or medication check session). This leadership strategy ensures that slippage by anyone; begets corrective action from everyone, not just from the leader. When such a culture is established, excessive rules and regulations, which some leaders mistakenly believe control behavior, can be avoided. Enlightened leadership understands that human relationships, and not bureaucracy, determine the great majority of an organization's success. Accountability is also supported by a culture that welcomes continuous quality improvement as an element of effective work. To cultivate

a sense of mutual accountability, the leader encourages mission-driven authority rather than reliance on the authority of the leader. When mission-driven authority is working well, the leader only has to be assertive when the team is stuck and fails itself.

Lack of Attention to Results

Related to a lack of accountability is Lencioni's (2002) noted fifth and final dysfunction—the *lack of attention to results*. She suggested this occurs when team members put their individual needs (such as career development or recognition) ahead of the team's common mission, in this case quality clinical care and wellness. Ideally, the team's collective mission should align with every individual team member's personal mission so that there is an overarching "win–win" situation between the individual and team mission and there is an attitude of "both/and" instead of "either/or." Unless the team is focused on clear deliverables and outcomes, there is a tendency for the team to become lackadaisical and complacent, as there is a lack of a challenge mentality shared by the group collective. This lackluster approach to teamwork does not inspire the achievement-oriented team members. If a team is not clear about its goals and members are easily distracted by personal politics and selfish, non-mission-driven behaviors, the results can become secondary and even nonexistent. However, teams that focus on their results motivate employees who want to "save lives and make a difference"—the Community Mental Health Council, Inc.'s motto.

Well-led multidisciplinary treatment teams can be honed into synergistic and prolific systems. Publically assessing and recognizing outcomes adds an extra incentive for teams to focus on results and promotes "systems thinking" (Senge 1990), which leads to interdependency and teamwork. Leadership cultivating a results-oriented team needs to be selfless and avoid taking credit for successful teamwork. Team members who facilitate good teamwork and who make real contributions to the achievement of group goals should be rewarded.

While there are various obstacles to healthy multidisciplinary team functioning, there are also collective characteristics that buffer a team from possible pollutants. Lencioni (2002) underscored that cohesive teams (a) trust one another, (b) engage in unfiltered conflict around ideas, (c) commit to decisions and plans of action, (d) hold one another accountable for delivering against those plans, and (e) focus on the achievement of collective results. Senge (1985) eloquently adds to these traits and synthesizes the effects of such a team environment:

> Trusting people to be creative and constructive when given more freedom does not imply an overly optimistic belief in the perfectibility of human nature, it is rather a belief that the inevitable errors and sins of the human condition are far better overcome by individuals working together in an environment of trust, freedom, and mutual respect than by individuals working under a multitude of rules, regulations, and restraint imposed upon them by another group of imperfect people.

Managing the Process of Conflicts on Multidisciplinary Treatment Teams

Goldsmith (2007) described several transactional team member behaviors that disrupt team functioning and lead to conflict, requiring monitoring and correction. The first is too much competition, such that the goal is winning and the team's mission forgotten. This competition can manifest intellectually, as there are some team members that strive to display a superior intelligence at the cost of listening to others. Related to this are individuals' tendencies to make destructive or negative comments that may be infused with sarcasm or derision. There may also be team naysayers who emphasize potential pitfalls instead of possible solutions. At times, there are others who are frequently angry and use anger to control the team process. Another destructive dynamic on treatment teams is the withholding of information to gain personal advantage. Just as a team or person can express too much or too little criticism, a team can also have too much or too little praise. Some team members claim undeserved credit, make excuses or blame others for disruptive

behaviors. Team leaders may also contribute to derailment, by "playing favorites" and/or failing to assume responsibility for poor decisions.

In order to manage conflict in multidisciplinary treatment teams, the importance of mission has to be underscored. The qualities of, functional teams mentioned above should be emphasized. As suggested earlier, the main mission of a multidisciplinary treatment team should not only be quality clinical care for mentally ill patients, but also attention to issues of wellness (Keyes 2007). Whatever the details of a team's core mission principles, they must be worked out uniquely by each team. The buffering characteristics previously described, engender interdependency and synergy, leading to the realization of targeted outcomes and even positive "side effects" (e.g., good relationships). Using mission and engagement effectively can smooth out and in many cases prevent conflicts. Attaining the team traits of interdependency and synergy is not easily achieved, and the team must understand that this is a process. Senge et al. (1994) indicates there will be times of frustration and even embarrassment, because while the idea of working together may not be new, the prospect of "learning together" quite often is new. In short, through effective mission-driven leadership, a team is able to commit to its goal. A well functioning team is conceptually unified about where they are going and that overall goal takes precedence over whatever conflict arises. DePree (1992) likens this quality of leadership with a jazz-band leader's aspiration of facilitating each player's opportunity to "do their own thing," while still maintaining harmony in the music the band plays.

There are several types of authority that leaders might use to manage a multidisciplinary team: (1) *legitimate authority* where there is a designated leader of the team who has the assigned power to reward and sanction various team behaviors, (2) *charismatic authority* where there is a person who has "winning ways" with people that causes the team to follow their lead, and (3) *traditional authority* where there is a person who is the oldest member of the team and who understands the history and process of the team (Bell 1974). It is ideal to have elements of all three types; however, the type of authority is not as important as the manner in which a person leads. This manner has been previously described, with a focus on trusting others to carry out their responsibilities and have good judgment, being vulnerable and open, supporting self-reflexivity (i.e., being open to looking inward and evaluating oneself), assessing results, bolstering mutual accountability, and encouraging others.

In many ways the team is much like a family. When functioning poorly it may be a source of distress and impede the progress of the people it is designed to help. When functioning well, it can accommodate and evolve when conflict arises. When this is the case, it provides a sort of home base for the team member, and a significant source of support and affiliation. If the team fails to be coherent it is unlikely that it will be successful in accomplishing its mission. It must work on its social and emotional team intelligence until some an adequate level of cohesiveness can be achieved.

Good Leadership, Personal Leadership

Essentially, good leadership consists of the act of making a significant difference through people, which ultimately requires the effective execution of emotional and social skills. This process of becoming a good leader requires study of leadership and management, personal leadership, and a true respect for humanity. Good leadership requires connecting every day to your deepest and most enduring values, exemplifying integrity, caring for your loved ones, making a difference through your work, and inspiring hope within the people around you. Good multidisciplinary leaders follow their followers and tend to have an irrational sense of hope. Strong leaders are able to face the truth about their own weaknesses and help others see their weaknesses by having courage and compassion. Covey (1989) stated, "…to achieve that balance between courage and consideration, is the essence of real maturity…" (p. 219). Good leaders believe in "creating" the future by cultivating "shared vision" (Senge 1990)

on the team and facilitating movement toward that vision. They embody their values and motivate others through their example. In other words, good leaders live in such a way so that when their team thinks of integrity, authenticity, enthusiasm, commitment, caring, and being on a mission, the team thinks of them.

With the right execution of good leadership and the application of good team principles and values, a healthy multidisciplinary team will emerge that embodies the following characteristics: (1) being proactive (Covey 1989) toward the mission, (2) engaging in collaboration instead of competition, (3) seeing the big picture instead of fragmentation, (4) seeking to understand patterns instead of cause–effect, (5) looking for deeper causes instead of surface symptoms, (6) engaging in ongoing learning instead of quick fixes, (7) studying process instead of events, (8) understanding "both/and" instead of "either/or," (9) making a point of seeing opportunities instead of threats, and (10) attempting to be anticipatory instead of being crisis-driven. Successful teams recognize that conflict is healthy, even vital, for long-term success. Senge (1990) reiterated this point and asserted that a by-product of great teams is that conflict results in production of outcomes and free flow discussions that lead to better alternatives and discovery of new answers. Covey (1989, p. 271) also supported healthy conflict and emphasized, "synergy means 1 + 1 may equal 8, 16, or even 1,600." Thus, synergy is worth the conflict because of the end result.

Conclusion

The ideal model of comprehensive CMHCs has been developing over decades now. Because behavior is complex and multidetermined, the various "treatments," comprehensive CMHCs are expected to deliver are multifarious. Accordingly, multidisciplinary teams require the vast array of biotechnical and psychosocial technologies needed to deliver the services and treatments necessary for community mental health. Due to the diverse nature of multidisciplinary teams, there are myriad opportunities for team dysfunctions to harm healthy outcomes for team members and the consumers/patients they serve. Drawing extensively on the excellent work of Leniconi (2002), Senge (1990), Senge et al. (1994), DePree (1992), and Covey (1989), we highlight the five dysfunctions of team and potential behaviors that can interfere with optimal treatment and service outcomes that the Community Mental Health Council, Inc. used with success.

We also provide suggestions for preventing these dysfunctions. This chapter highlights the issue of managing conflicts on multidisciplinary teams and how being mission-driven helps to create a team culture focused on the results and connected values. Drawing on various leadership strategies our team has applied in a comprehensive CMHC context, the authors make suggestions for leaders of multidisciplinary treatment teams. Multidisciplinary team leaders need to thoroughly immerse themselves in leadership and management and learn these social and emotional "soft skills" if they are going to lead healthy teams that get the job of treatment and service accomplished in an effective manner. Our collaboration focuses on various transactional team behaviors that are particularly toxic to cultivating healthy transformational team interactions, and we provide various paradigmatic quotations that should guide the team process. Finally, this chapter focuses on the need for good leadership to keep multidisciplinary treatment team processes healthy, creative, fun, and productive for members and recipients of the team's treatment and service.

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19 Psychiatric Rehabilitation Methods

Richard Warner

Principles of Social Intervention

Psychosocial rehabilitation offers a number of program models, refined over years of research and practice, which aim to improve the social inclusion of people with serious mental illness and to reduce the symptoms of illness and the handicap which they create. But the field is more than a series of programs. Rehabilitation practice is based on a set of principles or values which we inherit from 200 years of social psychiatry. These principles, set out in Table 19.1, have been "rediscovered" in the great social movements in psychiatry of the past two centuries, the latest of these being the Recovery Model or Movement. The fact that these values have been rediscovered on several occasions tells us that they have been periodically abandoned, so it is important for us to recognize and accept the centrality of these principles to the work that we do. The best treatment models available will not thrive in a treatment setting which neglects the values on which they are based.

Moral treatment, made vivid by images of Pinel striking the chains from the inmates of the Bicêtre asylum in 1793, but better illustrated by William Tuke's contemporaneous development of the York Retreat, brought us the principle of minimal use of coercion and the understanding that patients' self-control can be enhanced by respectful treatment in a home-like environment and by rewards rather than punishment. Eighteenth-century private madhouse operators tried to outdo one another in optimism, by extolling the likelihood of recovery from mental illness if only family members would seek their services in a timely way (Warner 2004). These principles of moral treatment were lost during the era of large asylums in the nineteenth century, but the consumer-driven US mental hygiene movement, which established institutional reforms, reintroduced the notion of therapeutic optimism, and demonstrated the importance of collaborating "with leaders in education, law, religion and social work" (p. 743) (Beers 1932).

The Great Depression brought a return to institutional confinement, but the post-WWII northern European social psychiatry revolution, which preceded the introduction of antipsychotic drugs, opened the locked asylum doors, abolished mechanical restraints and demonstrated the benefits of early discharge from hospital and work therapy. British psychiatrists introduced the "therapeutic community" into psychiatric hospital wards across the country. Under this approach, staff shared power with patients in the running of the hospital units, nurses' abandoned their uniforms, staff and patient roles were blurred and, thus, the concept of patient empowerment was introduced into psychiatry (Warner 2004). The same approach was simultaneously

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Table 19.1 Principles of social interventions in psychiatry

Treatment approach
Multidisciplinary, flexible, empowering
Reduced reliance on drug treatment
Consumer participation in treatment
Family support and education
Treatment location
Local and accessible
In the community
Treatment setting
Small, domestic, normalizing
Encouragement of individual self-control
Reduction of coercion and confinement
Involvement of the larger community
Collaboration with other social agencies
Fighting stigma
Political advocacy
Respect for human rights
The importance of client communities
Empowerment: transfer of power from service providers to service users
The value of work
Therapeutic optimism
Understanding biological, psychological, social, cultural, and political-economic factors

being introduced into community practice in New York City. Fountain House, the first psychosocial clubhouse, was founded in the city in 1948 by ex-patients of Rockland State Hospital (Leff and Warner 2006). Members and staff worked together to run the program, creating, in the process, a form of institutionalized empowerment of people with mental illness which was to long outlast the hospital-based therapeutic community. The 1990s saw an explosion in the number of psychosocial clubhouses, both in America and around the world, and the introduction of another consumer-driven psychiatric social movement—the Recovery Model—a central tenet of which is empowerment. At this stage, we may take a look at the influence of the Recovery Model and at the value of the psychosocial clubhouse.

The Recovery Model

The Recovery Model is covered in detail in Chap. 7. The model, which is influencing service development in Britain, the USA, and elsewhere (Ramon et al. 2007), refers both to the subjective experiences of optimism, empowerment, and interpersonal support experienced by people with mental illness and their informal care providers, and to the creation of services that engender optimism about outcome from illness and a support for human rights. The roots of the movement may be found in both the consumer movement and in psychosocial rehabilitation. Consumers have reinforced the drive towards empowerment, collaboration, and recognition of human rights. Rehabilitation professionals, on the other hand, have emphasized the need for services that recognize the value of work and the sense of community in the lives of people with mental illness, and the importance of environmental factors in helping people with psychiatric disorders achieve their best functioning potential (Jacobson and Curtis 2000).

The model calls for the provision of education about psychiatric disorders as a way to empower consumers to collaborate with service-providers in managing their own illnesses. Collaborative models, such as the psychosocial clubhouse and educational programs that involve both professionals and consumers as teachers, are seen as important elements of recovery-oriented services. The model has generated renewed interest in fighting stigma and the creation of user-run services that offer advocacy, mentoring and peer support via such mechanisms as user-run "warmlines" (peer-to-peer supportive chat-lines) and drop-in centers (Jacobson and Greenley 2001; Shean 2007).

The scientific evidence supports such central components of the recovery model as optimism about outcome, and the value of empowerment and peer support. One of the most robust findings in schizophrenia research is that 20% of those with the illness will recover completely and another 20% or more will regain good social functioning (Warner 2004). Much recent research suggests that working helps people recover from schizophrenia, and advances in vocational rehabilitation have made this more feasible (Leff and Warner 2006). A growing body of research supports the concept that empowerment is an important component of the recovery process and that consumer-driven services are valuable in

empowering the person with schizophrenia and improving outcome from illness (Warner 2010).

Psychiatric rehabilitation provides a road to recovery. The goal of rehabilitation is to help people with a disability enjoy the best and fullest life possible. It offers a route to working, making friends, having fun and taking on responsibilities—in short, full citizenship. The person with disability picks his or her personal objectives and the rehabilitation service aims to reduce the disability and make goal attainment and recovery possible. This chapter outlines some of the psychiatric rehabilitation models and approaches that mental health professionals and others have developed over the years, incorporating the values inherent in the Recovery Model and other social movements in psychiatry.

Vocational Services

There is good scientific evidence that working helps people recover from serious mental illness. At a macroeconomic level, we know that outcome from schizophrenia is worse (Warner 2004) and admissions to hospital of working-age adults with psychosis are greater (Brenner 1973) during periods of increased general unemployment. At the individual level, numerous controlled studies conducted since the early 1990s have identified improved nonvocational outcomes for subjects with serious mental illness who are working. Participation in an effective vocational program or having paid employment is associated with reduced psychiatric hospital admissions, reduced health-care costs and decreased positive and negative symptoms of psychosis. Successful work programs lead to increased quality of life, improved self-esteem, enhanced functioning, and an expanded social network (Leff and Warner 2006).

The Psychosocial Clubhouse

The psychosocial clubhouse is a consumer-driven rehabilitation model with a strong vocational focus which harnesses the benefits of client empowerment to increase members' skills and work preparedness and assists members in obtaining employment. (The model is discussed in detail in Chap. 30.) From simple beginnings, Fountain House in New York City achieved an international reputation, receiving hundreds of visitors a year. By 2009 there were 330 clubhouses in 27 countries around the world. Central components of the model are democratic decision-making and governance and the "work-ordered day"—a structured 8-h day in which members and staff work side-by-side on clubhouse work. The clubhouse is a space owned by the members, not the treatment system (Beard et al. 1982; Macias et al. 2001). Empowerment, treating the person with mental illness with respect, absence of coercion (membership must be voluntary), and the importance of work are central principles.

The emphasis on work is evident in the employment programs generated by psychosocial clubhouses. Initially, these work programs took the form of transitional employment programs in which temporary (3–9 months) part-time job placements were found for members in local businesses. Job coaches learned how to do the job, trained the member, and provided long-term support to him or her in the position. More recently, these placements have taken the form of continuous supported employment, in which the job placement is permanent. The approach has grown into a successful model with broader reach than the clubhouse.

Supported Employment and Individual Placement and Support

Supported employment, and its more recent refinement, individual placement and support (IPS), have been proven effective, in a large number of studies conducted in North America and several other countries, with rates generally running from 50 to 75% compared to control rates of 9–40% in placing and maintaining people with mental illness in competitive work (Bond et al. 2008). This vocational approach is discussed in more detail in Chap. 25. The core principles of the model include a focus on competitive, rather than sheltered, employment; rapid job search,

instead of extended preemployment assessment and training; integration of the vocational and treatment services; paying attention to clients' job preferences; and providing time-unlimited, individual job support (Bond 2004). Inherent in this approach are some important principles of social intervention—involving the community (in this case, employers) in assisting the social integration of people with mental illness, using a noninstitutional approach (no sheltered workshops), and showing respect for the person's preferences and strengths.

Social Firms (or Affirmative Businesses)

Another vocational model which has gained strength in recent decades is the social firm. Social firms, or affirmative business as they are known in North America, are businesses created with a dual mission—to employ people with disabilities and to provide a needed product or service. The model was developed for people with psychiatric disabilities in northern Italy in the 1970s and, by diffusion, has gained prominence throughout Europe and Australasia. Independent of European influence, affirmative businesses have also developed in North America (especially Canada) and East Asia. Over a third of employees in social firms are people with a disability or labor-market disadvantage. Every worker is paid a fair market wage, accommodations are made for disabled workers' needs, and all employees have the same rights and obligations. Hard to achieve, but important nevertheless, the business must operate eventually as a viable concern, free of subsidy. Advantages of the social-firm model include opportunities for empowerment and the development of a feeling of community in the workplace (Warner and Mandiberg 2006).

The first social firm was set up in 1973 as a worker cooperative for previously hospitalized patients during the deinstitutionalization of San Giovanni Hospital in Trieste in northeastern Italy. Within 10 years, the business, which employed workers to clean public buildings, was employing 130 workers. Over the next 20 years, a consortium of businesses was developed which included a café, a restaurant, a transportation business, a building renovation company and many others, with an annual income of $14 million. The family-style Hotel Tritone, one of the early businesses, proved to be particularly successful and has been franchised. All office- and street-cleaning contracts for the municipality of Trieste are currently awarded to social firms. Over 300 people with disabilities or disadvantages, half with mental illness, are currently employed in the Trieste cooperatives and earn a full market wage, and another 200 people diagnosed as having mental illness hold training positions reimbursed by governmental stipend (Warner and Mandiberg 2006).

The model has spread widely in Italy and interest in social firms has increased throughout Europe. By 2005, there were over 8,000 such enterprises in Europe with 80,000 workers, 30,000 of whom had psychiatric or other disabilities. In Germany, second only to Italy in number of social firms, there were over 500 such companies in 2005, with a combined workforce of over 16,000 employees, 50% of whom had disabilities. Before 1997, there were just six social firms in Britain. Since then, with the assistance of the support group Social Firms UK, the number has grown to more than 150, nearly half of which are considered "emerging" social firms, meaning that they still use some subsidy and are not yet financially self-sustaining. Catering and horticulture are the largest business sectors. Irish Social Firms, in Dublin, illustrates the importance of business viability. In the 1990s, this consortium operated a restaurant, a lunch counter, a wool shop, and a furniture store, but these businesses have closed in recent years because of the subsidy required to sustain them (Warner and Mandiberg 2006).

Social firms may achieve success by finding the right market niche. Many gain a market edge by competing for contracts with public agencies, such as hospitals, which often have a special interest in the social inclusion of people with disabilities or a strategic need to be seen to serve the public interest. They may also have practical market advantages. A cleaning business in Pordenone, in northern Italy, successfully developed contracts with public facilities because the unionized workforce it replaced was relatively inefficient.

The market niche may come from workers' special qualities. People with disabilities, for example, may have unusual reserves of empathy and patience when employed as home health aides. The public orientation of social firms can help them earn contracts through a willingness to tackle community problems—such as salvaging abandoned motor scooters to clean up a run-down section of the city (Warner and Mandiberg 2006).

Social firms often select labor-intensive business options to maximize employment while minimizing capital investment. Common choices include cleaning services; handmade products, such as wooden toys; organic food production that is not driven by investments in machinery and fertilizer; car washes; and bicycle repair. At times, however, a social firm consortium may choose to develop a business that is profitable but employs relatively few people with disabilities in order to use these earnings to offset other losses (Warner and Mandiberg 2006). A profitable venture of this type is the consumer-oriented pharmacy in Boulder, Colorado (Leff and Warner 2006).

Social firms offer some advantages over the supportive employment model. For example, they provide an opportunity for developing a sense of community in the workplace. A manager of a social firm in Trieste described this community feeling as "a small extended family." The supportive atmosphere may explain why the rate of transition from social enterprises into competitive employment is low in most countries (Seyfried and Ziomas 2005). Studies show that belief in an organization's social mission enhances worker participation and promotes organizational success (Warner and Mandiberg 2006).

Restoring Strengths and Abilities

Cognitive Behavioral Therapy for Persistent Psychotic Symptoms

Despite the long-held belief that it is a pointless exercise to try to dissuade people from holding tenacious delusional beliefs, recent research reveals that talking to people about their psychotic symptoms, and about their meaning to the individual, can lead to an improvement in symptoms. It emerges that gently challenging the evidence used by people with psychotic disorders to support their delusions, offering alternative viewpoints, testing reality, and enhancing coping strategies can be helpful. This approach is discussed in Chap. 13. A course of treatment may extend for ten or more sessions. After establishing a trusting relationship between therapist and patient, the therapist may gently test the patient's beliefs as in the following illustration:

Patient: "The Mafia has my house under surveillance."

Clinician: "Well, that is possible…. But why do you think it is the Mafia? Could it be some other organization? Or is something else happening altogether? How could we find out?" (Turkington et al. 2006) (p. 367).

Cognitive behavioral therapy has been shown to be effective for persistent psychotic symptoms in people who are resistant to treatment with antipsychotic medication (Wykes et al. 2008; Pinninti et al. 2010). The goal is not to persuade the patient that he or she has a mental illness. Rather, it is to reduce the severity of the symptom or the distress it causes. Patients are helped to identify coping strategies that may reduce both the cues and reactions to such symptoms as hallucinations or delusions. For one person, being alone or bored may be a cue to an increase in hallucinations; he or she can be taught to adopt strategies to reduce isolation or boredom. Others may learn to reduce auditory hallucinations by humming, conversing with others, or even reasoning with the voices and telling them to go away and come back later. Similarly, a person might be taught to test the reality of delusional beliefs against the therapist's interpretation of events and, for example, return to a church social group about which he or she had harbored paranoid fears (Tarrier et al. 1999). The approach does not reduce relapse rates in psychosis, but is effective in reducing distress resulting from positive symptoms (Garety et al. 2008).

CBT for persistent psychotic symptoms has been incorporated into the American Psychiatric

Association practice guidelines for the treatment of schizophrenia (American Psychiatric Association 2004) and into the Schizophrenia Patient Outcomes Research Team (PORT) recommendations (Lehman and Steinwachs 1998). A recent review of the literature concludes that we now have an effective psychotherapeutic intervention for people with schizophrenia (Turkington et al. 2006). Clinicians who have become accustomed to simply establishing the existence of hallucinations and delusions in their patients may now need to pay more attention to the content of these symptoms.

Cognitive Remediation

More attention has been paid, in recent years, to the cognitive symptoms of psychosis—such handicaps as decreased processing speed and poor attention, concentration, and working memory. Cognitive impairment, along with positive, negative, and affective symptoms, is a core feature of schizophrenia. The evidence suggests that it is correlated with work functioning, social relations and the capacity for independent living and is an impediment to gaining benefits from psychosocial rehabilitation (McGurk et al. 2007). Forthcoming editions of the Diagnostic and Statistical Manual for Mental Disorders are expected to direct more attention to cognitive deficits in psychosis. The increased attention to cognitive difficulties has stimulated greater attempts to rectify them. Pharmacological interventions have shown little effect on cognitive deficits (Marder 2006), but cognitive remediation programs, employing such strategies as repeated practice, teaching to improve cognitive functioning, strategies to compensate for impairments, and group discussion have shown some promise. Reviews of cognitive remediation in schizophrenia have suggested that the method produces modest benefits on cognition but has little or no impact on functioning (Krabbendam and Aleman 2003; Pilling et al. 2002). A recent meta-analysis concludes, however, that cognitive remediation produces moderate improvements in cognitive performance and functioning and that the impact on functioning is greater in studies that provide psychiatric rehabilitation in addition to cognitive remediation (McGurk et al. 2007). Most remediation programs now employ computer-based training among their methods, but such advances in technology do not appear to have improved outcomes appreciably. Programs that include strategy coaching have greater effects on functioning; this approach targets memory and executive functions by teaching such strategies as problem solving and chunking information to facilitate recall (McGurk et al. 2007).

Social Skills Training

Social skills training is a method of teaching people with serious mental illness who have social and emotional skill deficits how to improve these basic skills. The approach, which is based on behavioral learning principles, was developed by Robert Liberman in the 1960s (Liberman 2008). The method has enjoyed some popularity in the USA but, although the social skills manual has been translated into 23 languages, it has not been adopted to any great extent in other countries (Liberman 2008).

In a typical course of training, after establishing a therapeutic alliance and conducting a behavioral assessment, the trainer and trainee will establish long- and short-term goals for dealing with a specific interpersonal problem and develop a scenario to achieve these goals through role-playing with other members of the group. The patient is encouraged to perceive how he or she might have handled a situation differently in the role play and earns positive feedback for improvement in skills. When the patient is demonstrating sufficient skill, he or she may be given homework to practice with people outside the class. The final, and perhaps most difficult, step is to assist the patient in generalizing improvements in social skills into everyday, real-life settings (Liberman 2008). It is the doubts about whether this process of generalization can be accomplished successfully, that has put a damper on the diffusion of the approach more broadly. A meta-analysis of studies of social skills training published in 1996,

revealed that although the approach was effective in teaching patients interpersonal and assertiveness skills, few studies have examined whether training in the hospital setting generalizes to social interactions in the community (Dilk and Bond 1996). For whatever reason, adoption of the model has not been strong and Liberman himself reports that "its use is still limited to a relatively small number of behaviorally oriented practitioners" (Liberman 2008) (p. 271).

Working with Families

Behavioral Family Management

Behavioral family management or the psychoeducational approach to working with families of people with serious mental illness is covered in detail in Chap. 28. The approach is based on the robust results of research conducted in several countries in the developed and developing worlds. This research reveals that people with schizophrenia living with relatives (by birth or marriage) who are critical or overinvolved (referred to in the research as high "expressed emotion" or EE) have a much higher relapse rate than those living with relatives who are less critical or intrusive (Leff and Vaughn 1985; Parker and Hadzi-Pavlovic 1990). Some studies have shown that relatives who are less critical and overinvolved exert a positive therapeutic effect on the person with schizophrenia, their presence leading to a reduction in the patient's level of arousal (Tarrier et al. 1979; Sturgeon et al. 1984). There is no indication that the more critical and overinvolved relatives are abnormal by everyday standards. It is more likely, in fact, that the families in which people with schizophrenia do well have adapted to having a person with a psychotic illness in the household by becoming unusually low-key and permissive (Cheek 1965; Angermeyer 1983).

Several studies have shown that family psychoeducational interventions can lead to a change in the level of criticism and overinvolvement among relatives of people with schizophrenia and a reduction in the relapse rate (Berkowitz et al. 1981; Falloon et al. 1982). Effective interventions provide three basic ingredients: (1) detailed information about the illness for the family and patient, (2) help for the family to develop problem-solving mechanisms, and (3) practical and emotional support (Leff and Vaughn 1985; Falloon et al. 1982; McFarlane 2002; Leff 1996).

Family psychoeducational approaches have all proven highly effective in reducing the rate of relapse in schizophrenia. The approach, however, has not disseminated at all broadly in community psychiatric practice anywhere in the world. Only 7% or fewer people with schizophrenia in the USA, for example, get involved in a family intervention program (Lehman and Steinwachs 1998). There are a number of explanations for this. In many areas, few people with schizophrenia live with family. In addition, organized attempts to disseminate the model to mental health managers and providers have been almost nonexistent because, unlike psychopharmaceutical products, no one stands to make a profit from marketing the approach, and those who could benefit most, organizations of families of people with serious mental illness, have often considered any form of family intervention to be stigmatizing and have not lobbied for dissemination of the model. Recently, however, the National Alliance on Mental Illness in the USA has launched a Family-to-Family education program on mental illness taught by trained family members which has been shown to be effective in enhancing coping and empowerment of families (Dixon et al. 2011).

Most of the work cited above was published in the 1980s or early 1990s, and little development of the model has occurred in the past 15 years. However, the advent of the internet has opened the door to new possibilities for disseminating the model. Recent publications describe a Web-based psychoeducational intervention for people with schizophrenia and their families (Rotondi et al. 2005, 2010). The approach offers a secure internet forum for family members and consumers led and moderated by trained facilitators and an online library of educational resources. A randomized controlled trial of the approach led to a large reduction in positive symptoms in the consumers and a growth in knowledge about schizophrenia in both patients and family members

(Rotondi et al. 2010). Online delivery of family psychoeducation may have a promising future.

The Confidentiality Barrier

There is a simple approach which would have a big impact on the involvement of families in treatment—talk to them. Too often family members discover that they cannot get basic information about their relative when they call the hospital or clinic. They are told that the information is confidential and protected by statute. Common sense and common courtesy, at the least, should tell us that every patient, upon admission, should be asked if he or she would like to sign a release of information form allowing staff to communicate with specific family members. This is rarely done in US hospitals and clinics. Even without a signed permission to release information, communication is possible. As Robert Liberman writes:

> Too many practitioners pay obeisance to a misguided conception of privacy and confidentiality. There is no violation of confidentiality when a clinician *solicits information from family members*. Can anyone picture an internist or surgeon failing to invite a close family member to provide confirming and converging information regarding the patient as a key element in diagnosis and choice of treatment? Relatives are lucky if they get in to see the professional responsible for the patient's treatment, much less hear of the patient's diagnosis and prognosis. Plainly speaking, relatives are ignored by mental health professionals (Liberman 2008, p. 299).

Housing Strategies

Integrated Versus Clustered Living

Supported housing models are discussed at length in Chap. 29. As in other areas of rehabilitation practice, housing models are influenced by values. One value-based issue which comes into play in devising approaches to housing is the question of whether it is better to utilize the mutual support that exists in client communities or to pursue the more usual principle of "mainstreaming." To avoid creating mental health "ghettoes," service planners often seek to place people with psychiatric disabilities in dispersed housing. They hope that by dispersing people in the broad community, community members will provide some of the needed support. This rarely happens, however, and the people with mental illness often have to turn to mental health professionals for support. For some, the more direct route to social inclusion and successful community living may be through enclave communities of people with the shared experience of mental illness.

A program in Santa Clara County, California, explored this notion in the 1980s and 1990s (Mandiberg 1995). Instead of dispersed housing, clients' apartments were located so that no one was more than 5 min walking distance from the other residents—neither dispersed nor overly clustered. In the geographic center of the housing, a space was rented for community activities. Instead of residential supervisors, staff were hired as community organizers and told that their task was to help foster a mutually supportive community. The success of the Santa Clara County clustered apartment approach reminds us that the mutual support available in client communities may be turned to advantage and should be considered as an option in developing housing strategies for people with serious mental illness.

Summary

Values—both hidden and evident—shape our psychiatric rehabilitation models, and the recovery movement provides a series of values which have been guiding this work. Recognition of the importance of empowerment for consumers of psychiatric services heightens our interest in the clubhouse model and other cooperative programs. An emphasis placed on work rehabilitation can move us from a day-treatment approach towards the supported employment model and, thus, change many other aspects of a rehabilitation service. A value placed on mutual support among clients vs. mainstreaming will direct us toward a clustered apartment program or increase our interest in social firms over supported employment.

A concern with human rights and with minimizing coercion encourages us to design small, open-door, domestic facilities for acute care, whereas an emphasis on cost-efficiency will lead us to develop large, locked facilities with the capacity to use restraints and seclusion. Recognizing the importance of families will guide our interactions with caregivers, and optimism about outcome from illness will color everything we say and do. Some US psychiatric residency training programs, however, offer no education on psychiatric rehabilitation models—none at all. This is a value that bears closer scrutiny.

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20 Psychiatrist-Led Outpatient Groups: Putting Our Minds Together

Leslie Hartley Gise and Benjamin Crocker

Introduction

Psychiatrist-led outpatient group therapy for patients with significant mental illness or substance use problems is a powerful treatment vehicle for combining medical and psychosocial treatments in an efficient and accessible format. It was once widespread as the focus of treatment for persons with severe illness as they were shifted from state hospitals to community mental health centers (Stone 1993). Despite significant clinical evidence for its effectiveness, few psychiatrists currently run groups for these patients. Most psychiatrists experienced with group psychotherapy do not treat patients with severe mental illness and most psychiatrists specializing in the treatment of severe mental illness do not run groups. Today, group psychotherapy is rarely part of psychiatric residency training. Despite this course of events, as economics create pressure for systems change, group medical visits as an alternative to individual appointments will likely be encouraged. Likewise, as mental health and primary care systems converge, group treatments offer an attractive and efficient option for people seeking care outside traditional behavioral health settings.

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History

In 1927, Pratt applied group treatment originally developed for *tuberculosis patients* in 1905 to patients with *medically unexplained physical symptoms* and found improved outcomes with increased efficiency (Pratt 1953; Sabin 1990). Pratt incorporated a biopsychosocial model that included outreach, an interdisciplinary involvement, spirituality, relaxation, and meditation.

Group psychotherapy became a prominent intervention in mental health services in England and the USA during WWII. In the period between the world wars, the effects of exposure to the traumas of war on both civilians and combatants came to be appreciated, and it was hoped that mental health services would reduce morbidity in both populations. However, the number of trained clinicians could not meet the demand for one to one contacts, and so group psychotherapy was attempted and proved to be helpful for many.

After the war, theories of group psychotherapy reflected the overall dominance of psychoanalytic theory, but in psychiatric hospitals and within growing community mental health centers the development of supportive and

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psychoeducational group therapy continued. In 1970, Yalom (1970) identified ten curative factors resulting from group therapy:

- Imparting of information
- Instillation of hope
- Universality
- Altruism
- The corrective recapitulation of the primary family group
- Development of socializing techniques
- Imitative behavior
- Interpersonal learning
- Group's cohesiveness
- Catharsis

Although there are a variety of formats used for group therapy, and some variability in structure and emphasis, most groups do incorporate some or all of these curative factors, including the medication management groups that we discuss in this chapter.

Since the establishment of Alcoholics Anonymous (AA) in the 1930s, groups became increasing important to persons attempting to recover from substance use problems. Although these group experiences initially developed independent of professional clinicians, since the middle of the twentieth century they have been increasingly incorporated into professionally run substance use treatment programs. The American Psychiatric Association's (APA) practice guidelines currently recommend group treatment for patients with substance use disorders (Yalom 1970).

With the reduction in long-term state hospital stays that were facilitated by changes in social security laws and the development of effective medications, outpatient group therapy for patients with *severe mental illness* was used in many community programs starting in the 1960s to treat patients discharged from state mental hospitals (American Psychiatric Association 1995; Stone 1991).

When clozapine began to be used in the USA in the early 1990s for patients with treatment resistant psychotic or manic symptoms, treatment groups for patients taking this medication were developed to meet the demand for the special monitoring and psychoeducation required for recipients. Often, a single doctor–nurse team would manage all the patients in a large clinic who took clozapine. A similar scenario was observed in the early days of lithium use a couple of decades earlier when it was considered a complex and confusing treatment. Groups were also developed for the treatment of anxiety. Some of these grew out of marketing trials for antianxiety medications, which often offered treatment at little or no cost. The people who participated could access some ongoing services that had to be affordable with limited staff. Groups that combined ongoing prescribing of medication with behavioral and cognitive therapy were often organized to manage these service users. Groups have been used for a variety of other special populations including medical patients, psychiatric patients in medical settings, personality disorders, traumatization, and premenstrual syndromes, to name a few (Abrahamson and Fellow-Smith 1991; Gise 1989).

Efficacy

Reviews of psychotherapy for schizophrenia suggest that outpatient group treatment may improve social functioning and result in better outcomes (Gise 1989; Mosher and Keith 1980; Schooler and Keith 1993; Stone 1997). A pilot study found reduction in suicide risk factors with a 20-week group intervention (Stone 1998). Some data suggest better outcomes with group over individual treatment. In a study of patients discharged from a state hospital, group therapy patients were significantly less likely to be hospitalized than those receiving individual therapy (Bergmans and Links 2009).

With regard to *medication adherence*, group psychotherapy has been shown to maximize the benefit from psychopharmacology. For example, one study found higher, more stable serum lithium levels for patients with bipolar disorder (Prince et al. 1973) among group participants. For patients with both mental illness and substance use disorders, better medication adherence and better outcomes, including less psychiatric hospitalization, have been reported with dual-focus self-help groups (Colom et al. 2005). In a pilot study,

group treatment was found to increase sobriety in patients with bipolar and substance use disorders (Magura et al. 2002).

Several *controlled trials* of patients with schizophrenia have found better outcomes for group over individual treatment (Weiss et al. 2000; Donlan et al. 1973), with fewer hospitalizations (O'Brien et al. 1972) and less frequent relapse (Ward 1975). Recent randomized controlled studies with 5-year follow-up have found group psychoeducation for patients with bipolar disorder to have a long-lasting prophylactic effect with an increase in adherence and retention and a decrease in recurrence, time acutely ill, number of days in the hospital, frequency of hospitalization, and cost (Herz et al. 2000; Colom et al. 2003a, 2009). Controlled trials of group treatment of patients with schizophrenia have found significant positive effects on auditory hallucinations, social functioning, self-esteem, self-assertion and coping, with a reduction in hopelessness as compared to traditional care (Scott et al. 2009; Barrowclough et al. 2006; Borras et al. 2009; Wykes et al. 2005). Barrowclough used group cognitive behavioral therapy for psychosis. Clinical evidence supports a positive association between group treatment and better outcomes including improved medication adherence, retention in treatment, less hospitalization, and shorter hospital stays (Bright et al. 1999).

While there is a great deal of evidence regarding the effectiveness of group treatment, relatively little has been developed that looks specifically at psychiatrist-led group treatment of patients with severe mental illness. It has not been sufficiently studied in a systematic way to make definitive statements regarding its effectiveness relative to other forms of medication management or therapy. Anecdotally, we know that this approach is more promising in its capacity to help people make social connections and in expanding the amount of contact psychiatrists have with their clients. More studies of groups which incorporate psychiatrists and other prescribers for medication management are needed to establish a sound evidence base for psychiatrist led group treatment.

Advantages of Psychiatrist-Led Groups

Reduced Stigma and Balancing of Power Issues

Group expands the psychiatrist's knowledge of patients and their lives because of the more frequent contact and the opportunity to observe group members in a social context. Meeting in a group reduces the intensity of the therapist-patient relationship and the difference in power and status between the therapist and patient. Thus the leader becomes a member of the group; not only an authority figure. These dynamics serve to somewhat equalize the therapist-patient relationship and reduce the social stigma and alienation associated with emotional problems. The group leader begins to shift roles to some degree as they recognize their own issues and their need to be "in recovery" from the stigma of mental illness. As they do so, the therapist identifies with the feelings and experiences of other group members, which is quite distinct from the traditional role of the therapist.

> Desmond is a middle aged man with chronic schizophrenia, social anxiety disorder, mild mental retardation and a past history of polysubstance abuse. For years he said little in group but now says "You can say whatever you want. I feel at ease, more normal; that I'm not the only one. I feel safe. I can listen to people and understand. I feel connected and not alone. I don't have to talk but I can see everybody more often and I feel better after group and I get more ideas about how to solve problems."

In individual therapy, the content is limited to what the patient brings up. In group, content, emotions, interactions and opportunities are expanded, broadening the perspective of the therapist. Because the leader has an interaction in group which is more egalitarian and active, an enriched experience results which allows a more profound knowledge of the individuals in the group. This interaction is satisfying and productive; bringing out the strengths of even the most disabled participants. Most groups develop a degree of solidarity that offers a balance to the ascribed power of the psychiatrist and the treatment team, facilitating

shared decision-making. Because groups with co-therapists or multiple clinical participants demonstrate aspects of team dynamics, they allow patients to see the psychiatrist in a social nexus, and allow the psychiatrist to demonstrate collaborative interactions. Psychiatrists often obtain support from that team as well.

> Bertha, an elderly woman with chronic psychosis, faithfully attends group but speaks little. At the holiday party she came to life leading all the singing with her great voice and knowing all the words. She had never told anyone that she was a choir leader in her youth. Subsequently when asked about her church involvement, she eagerly belted out a favorite hymn. This made her feel good. She got a lot of praise and others were encouraged to share their talents. In contrast, before joining the group, her quarterly visits to her psychiatrist tended to be brief, and she was rarely asked much about her life, other than to ask if she was having psychotic symptoms or suicidal ideation.

More Frequent Contact

Group treatment can increase access by permitting more frequent visits, allowing more time to build a strong therapeutic alliance and provide some psychotherapy to persons to whom it would not otherwise be available. This is important because several studies have reported that a strong alliance enhances medication adherence (Schooler and Keith 1993). Seeing patients more frequently permits earlier identification of problems and provides the opportunity to intervene before symptoms become more severe (Gise 2004; Herz et al. 1991).

> Annette had bipolar disorder and medical illness and was in an abusive relationship. She chronically minimized her symptoms and had a history of impulsive suicide attempts. In individual sessions Annette minimized her symptoms and said little. She agreed to attend group, but initially said little. One day she became upset in group and asked to leave. The co-therapists and her peers urged her to stay and share her feelings Annette was able to do so, revealing emerging suicidal impulses. As a result of this session, she was able to request an overnight hospitalization for safety. This interaction turned the tide in her ability to ask for help and increased her trust in her caregivers and peers. Being in the presence of others sharing symptoms and feelings provoked the upset, but also allowed her to do the same.

The increased duration and frequency of group sessions and the observation of other clinician-patient interactions may help a patient feel more understood, even vicariously.

> Suzie was hospitalized after she became psychotic. She had stopped her medication and complained that her visits with her psychiatrist at the medication clinic were very brief and that the psychiatrist never seemed interested in what she had to say. After a short hospital stay she was stepped down to partial hospital, then intensive outpatient treatment, where she participated in several groups. She accepted an offer to start coming to an outpatient group that combined supportive psychotherapy and psychotropic prescribing, and told her case manager that she felt the clinicians in the group cared about her even though most of the time she did not talk much.

Several reports conclude that the cost of increased visits is more than offset by a reduction in emergency visits and hospitalization. An outside observer sitting in on a single group may not see much going on and be unimpressed, but for patients with severe mental illness with long histories of relapse and recurrent hospitalizations, stability and maintenance are significant achievements. Furthermore, long-term stabilization not only provides long-term cost benefits, but also contributes to improved outcomes and reduces the risk of relapse.

Focus on Rehabilitation, Recovery, and Psychosocial Issues

Group treatment facilitates recovery and addresses the task of reintegration into the community that confronts every patient after an episode of mental illness. In addition to independent living and employment, reintegration includes restoring and forming relationships, which are facilitated by group.

> Audrey is bright, but quite psychotic, disorganized and thought disordered. Although she comes to group regularly, she insists it is only for her shots. Nevertheless, she feels a sense of cohesion due to the prolonged interaction between staff and patients during group. In her 57 years, her paranoia has resulted in impulsive flight and moving every 2–5 years. For the past 11 years in group, she has stayed in one place in her independent housing, gone to school and worked part-time.

Psychiatry has recently been dominated by psychopharmacology with a disproportionate emphasis on medications in psychiatric training, continuing medical education, and the media. While medication has been invaluable in reducing psychotic symptoms, it is cognitive deficits and difficulties with interpersonal relations that interfere with recovery most. Both group cognitive behavior therapy (CBT) and group psychoeducation have been found to improve quality of life in patients with schizophrenia (Bechdolf et al. 2010). Psychiatrist-led "medication" groups provide the opportunity to integrate psychosocial care into treatment. Such groups also reduce the problems associated with split-treatment and allow clients to obtain most of the psychiatric, medical, and psychosocial services they need in one setting.

Recent studies show that people with severe mental illness get *worse medical care* and have higher morbidity and mortality than the general population (NASMHPD 2006; Faglioni and Goracci 2009). In group, when a medical issue comes up, it provides an opportunity for the psychiatrist to address a variety of issues related to prevention and health management. The group can be polled about their health practices and their involvement with a primary care doctor. It is an opportunity to encourage regular primary care visits and the monitoring of important health indices. There is seldom enough time to address these issues so extensively in individual sessions. Screening, triage, and education can be accomplished more effectively in group, allowing the psychiatrist to do some basic medical monitoring, detection, and referral. People may both over- and undeuse medical treatment and often communicate poorly. Group provides an opportunity for coaching effective self-advocacy and to rehearse the interaction with other providers.

Group also provides an opportunity to integrate psychosocial rehabilitation and medication management. Group activities may include social skills training, practicing assertiveness, vocational counseling, life skills training, problem-solving, role-playing, networking, linking patients to resources, and accessing multiple sources of support (Stone 2000). Psychoeducation is an important way to promote recovery and is done more efficiently in group (Liberman 2008).

Socialization and Recovery

Social isolation is one of the hallmarks of severe mental illness. Psychiatric patients feel different and distressed by their isolation. Ignorance and fear of mental illness is prevalent in our society and significantly affects the people treated by psychiatrists. Persons who hear voices or think about killing themselves feel that friends and family probably do not want to hear about it and it may not be in their best interest to talk about these things. Sitting in a room with other people who have these symptoms and face the same stigma and exclusion may be the only place a person can talk about such symptoms and feelings. When people with mental illness hear others talk about side effects or disruptive symptoms, it makes it easier for them to share their own symptoms and face and accept their own illness, which they may have denied. Furthermore, participants feel good and are empowered when they are able to help their fellow group members. Group helps individuals feel like people, not just "patients."

Many find the one-on-one therapy experience too intense and feel more comfortable and less threatened in group where they can gradually learn trust and build relationships.

> Wendy, a poor minority woman with a history of being abused and depression, said, "I didn't like the first meetings. But I listened to the other women with the same problems I was having, and I began to tell them things I'd never told anyone. The therapist asked us questions to change how we thought and I felt myself changing and getting stronger." After 2 months Wendy got out of her abusive relationship and 2 months later she got a job (Solomon 2001).

An atmosphere develops which is like a family or a club with a great deal of mutual help. Members' concern and willingness to help each other is a revelation and makes both those receiving and those giving help feel better. Even people who are very impaired are amazingly supportive and nonjudgmental of each other, creating an

atmosphere where members are appreciated and empowered. Sometimes, the pain and despair of these chronic illnesses emerge clearly. In contrast to traditional psychodynamically oriented groups where extra-group socializing is sometimes discouraged, in "medication" groups there is no prohibition against members' socializing outside the group, which is usually beneficial (Stone 2000, 1996).

> Ed and Jim are quite different but both socially isolated. Ed is older, depressed, drinking most of his life, not psychotic, working. Jim is young, bipolar, psychotic, functioning poorly with a long history of nonadherence to his treatment plan, especially psychotropic medication. Ed needs to lose weight and Jim needs to get out of the house. After a year in group, they started walking together 3 days a week.

Treatment group experiences can prepare patients to join freestanding community support groups and otherwise participate in recovery activities that go beyond the realm of clinical services.

Improved Adherence to Medication Plan

Some people with mental illness don't take their medication because they do not believe that they are sick. Group reduces denial, increases insight and eases the sting of acknowledging the presence of illness. Failure to adhere to medication plans is associated with poor outcomes and is the most common reason cited for hospital admissions (Ayuso-Guttierrez and del Rio Vega 1997; Weiden and Glazer 1997; Weiden and Olfson 1995). A growing body of evidence indicates that psychosocial interventions can improve adherence and outcomes (Kane 1997). Group increases client investment in the plan through healthy engagement and by providing information, validation and psychosocial support.

> Scott was shocked when lithium was recommended. He refused. He associated lithium with patients much sicker than he thought he was and was afraid of bad side effects. When Dennis said lithium was "good stuff" and that he had been helped by taking it for a long time, Scott said he would try.

The solidarity of the group and balancing of power between the group and the clinicians leading it support and demonstrate the process of shared decision-making, which improves adherence.

Group fosters engagement and the establishment of long-term therapeutic relationships based on trust. Medication in the context of a positive and trusting relationship with the clinician has been found to be associated with better adherence to formulated plans (Beck 2001). Review of the literature shows three factors to be associated with good outcomes: (1) relationships, (2) psychosocial rehabilitation, and (3) medication adherence. All three are facilitated by group treatment (Colom et al. 2003b).

Shared Group Leadership

Mental illness has a course that often lasts through life, such as high blood pressure or diabetes, and is rarely cured in a few sessions. Thus continuity of care is an important factor in treatment. In addition, many people with mental illness are extremely sensitive to loss. Groups facilitate continuous healing relationships with individuals and with the institution. Shared group leadership with multiple therapists provides continuity over time and eliminates the need to cancel the group when one therapist is absent. When one therapist is a trainee, leadership changes on a regularly scheduled basis. When one therapist is a junior colleague, shared leadership facilitates training. Clinical work in behavioral health can be stressful and co-therapists can provide emotional support for each other. When the co-therapists are from different disciplines, coleadership provides a broader spectrum of experience. A co-therapist arrangement allows an opportunity to more effectively move beyond content issues and to discuss group process. This type of debriefing fosters teamwork, and the capacity to work effectively together. Finally, with two people, the tasks of leading the group, observing, making chart notes and writing prescriptions can be divided (Table 20.1).

Table 20.1 Advantages of shared group leadership

Continuity
Training
Support
Feedback on process
Multidisciplinary teamwork

Barriers and Limitations

Financial

In our current system of financing medical care, group treatment by a psychiatrist is often reimbursed less favorably per patient than individual treatment. CPT codes used for medication management reimburse individual visits more favorably than group visits. Frequently, billing rules regarding Medicaid are different for hospital based and freestanding mental health clinics, and Medicare also has rules about the number of patients that can be treated in a group. A new billing code has been suggested to make psychiatrist-led group treatment more attractive financially. In many instances, the psychiatrist can meet briefly with group participants individually during or after the group. When these models are used, individual billing codes for medication evaluation, which are not time specific, can be used. If everyone understands this format as a standard procedure, it can work quite smoothly. With some imagination and flexibility, medication groups can be financially practical work despite current fee for service billing strictures. As psychiatric services become integrated into primary care, billing codes used for group medical visits in primary care may be appropriate for medication groups held in that setting.

Administrative Context

Community and public psychiatry is often practiced in organizations in which the group format is unfamiliar, and thus not supported by administrative staff. Issues such as having to pull a lot of paper charts in clinics without electronic records, or even the unavailability of suitable sized waiting and treatment rooms may be barriers to group treatment. Administrators need to be made aware of the advantages of group treatment: patient satisfaction, clinical care, reduced phone calls to clinic, increased productivity and access. As traditional agencies face the challenges of competitive and capitated contracting with payers in the context of changing practices (such as the development of the Medical Home), they need the support of consumer and advocacy groups who may appreciate the role of groups in supporting a recovery culture and access to services. Because so much psychiatric care is delivered individually and not in group, the group format is unfamiliar in many outpatient institutional settings and to many psychiatrists. The culture must change to make group more acceptable and to reduce the barriers to group treatment.

Training and Personal Characteristics

Training in group psychotherapy is not a core part of psychiatric residency education today, and many other professionals working in mental health systems also have little training in group work. Some psychiatrists are better suited to this kind of work and are naturally drawn to it, i.e., those with a good capacity for multitasking, a high tolerance for ambiguity and chaos, and good social skills. These skills can be taught, but this is done most easily in the early part of a psychiatrist's career. In any case, direct participation in groups is the best way to train future group leaders. Trainees from various disciplines can observe experienced group leaders as they assist in the facilitation of treatment groups. This approach provides opportunities for supervision and processing as well.

How to Start a Group

Intake, Recruitment and Preparation

All patients should be interviewed before being invited to join a group (Stone 2000). The psychiatrist or co-therapist who is leading the group

should do the intake. After the intake interview, if deemed appropriate, they can be offered group treatment. Many are resistant at first, some because they feel anxiety about talking in front of others. Others refuse because they do not want others to know their problems. It may be helpful to reassure prospective members that when they start group, they do not necessarily have to talk. They can also be assured that what is said in group stays in group and the group will regularly be reminded of this rule. Confidentiality issues may vary with the size of the community served, and some patients may benefit from coaching before starting group about how to use the group. It is sometimes helpful to note that people can discuss treatment and recovery issues without having to disclose sensitive personal issues. Over time, when their symptoms of anxiety, depression and paranoia are reduced and they become more comfortable with the leader, some people who were initially resistant become more comfortable with group participation. Clinicians are more persuasive in getting clients to try groups if they themselves believe that groups are often a superior modality, not a second class alternative for people who function at a low level.

Those individuals referred from inpatient, partial hospital and intensive outpatient programs that utilize group treatment may be more accustomed to groups and can easily be encouraged to continue group work as outpatients. It is often helpful to discuss the advantages of group participation and to then allow people to make their own choice about participation. By simply asking, "Are you willing to try it once?" and promising "If you don't like it, you don't have to come any more." many people will be willing to start. In most cases, after they come once, feel the non-judgmental atmosphere, and find that they are not forced to talk, they continue. Those who adamantly refuse should be seen individually but the invitation to group can be repeated every 6–12 months, especially if the doctor–patient relationship is stronger and the individual's symptoms are reduced.

An ideal group is 8–12 patients but larger and smaller groups may function effectively. Group duration may be 45–90 min. Some time should be allocated after each session for leaders to debrief and review.

Group Composition, Membership, Exclusionary Criteria

Most patients with severe mental illness are suitable for inclusion in group (Stone 2000). A few people who are especially needy or those with particular personality traits, (such as mood instability, impulsivity, entitlement, distrustfulness) may have difficulty tolerating groups. They may refuse to participate, or become too disruptive to continue. Individuals with a variety of psychiatric conditions can benefit from groups however, including those with acute psychosis, suicidal ideation, substance problems, and cognitive deficits Even group candidates who say that they only come to group because they are forced (e.g., the law and entitlements) often become engaged in the group over time and can definitely benefit from this treatment format.

Members are discouraged from bringing their children, but if child care is unavailable outside the treatment facility or within it, children can be accommodated on an "as needed" basis. Bringing children or other guests on a regular basis is generally discouraged however, unless group members specifically approve it. In a small, rural setting, a highly heterogeneous group can be successful and may meet less frequently than would normally be the case. In centers that serve larger numbers of people, candidates can be assigned to groups based on specific characteristics or experiences, or based on the issues that will be addressed. Group formats (supportive v. educational v. process) may be another factor that can be used to determine assignments. Diagnostic categories and level of cognitive ability are also sometimes used for that purpose. In homogeneous groups patients are more likely to form supportive relationship outside of group, while in heterogeneous groups patients can appreciate the universality of human feelings and problems despite differences in background, diagnosis and/or level of functioning. Homogeneous groups

facilitate sharing, bonding and cohesiveness while heterogeneous groups promote tolerance, understanding and sensitivity. These are generalizations though, and these characteristics are not mutually exclusive.

Flexibly Bound-Model

Many people have difficulty keeping regular appointments. The frequency of group meetings varies between weekly and monthly scheduling. Groups that meet frequently and have a fixed membership require the most discipline and commitment. Ultimately, the scheduling of groups sessions will depend on the resources available and the characteristics of group members. Many people can come to group weekly but for others, irregular attendance is the norm. Individuals who are more stable may prefer to come less often. A "flexibly bound model" empowers patients by allowing them to choose the frequency with which they attend (Stone 2000) and helps them learn to get help when they need it. Thus, people can titrate their attendance. Furthermore, this reduces pressure on therapists to address missed sessions. In contrast, in a psychodynamic, closed-membership, process group absence is viewed as resistance. Some groups may be flexible enough to permit some patients to come late and leave early. However, a certain minimum frequency of visits is usually required, along with limits on providing refills to persons who are not attending group. In large clinics or for groups with members who often miss appointments, very open "refill groups" can offer frequent face-to-face opportunities for people to get their medications refilled without having to wait for an available individual appointment.

How to Run a Group

Content, Setting and Duration

Groups may be focused on psycho-education, skills development, cognitive-behavioral treatment, support and/or interpersonal process or a combination. Kanas suggests that groups should focus on the "here-and-now" and can be effective in helping patients cope with a variety of symptoms, including psychosis (Gise 2004; Kanas 1996). Groups may start with some socializing around "coffee and snacks," but informal pre-group contact may go on in the waiting room anyway. Some groups have a specific agenda for each session, and some are time-limited and/or manualized. Although these groups are easier to study and require less improvisation and skill on the part of the leaders, there are advantages to ongoing groups with no set topics starting "where the patients are at" (Jensen et al. 2010). With ongoing groups, new members can be added at any time. With an open agenda, the leader can start with "Does anyone have anything special they would like to bring up before we start?" This lets members bring up something of special interest or concern and teaches them to prioritize urgent issues from routine ones. The leader can also initiate topics (e.g., psychoeducation on flu shots, disaster preparedness, relationship with spirituality). Since the distress and disability associated with many psychiatric diagnoses may persist, especially in populations with high social and economic stress, there are advantages to ongoing groups. Long-term treatment is required for many disabling psychiatric conditions and today the treatment of people with a variety of psychiatric diagnoses involves medication. For disorders that tend to be more phasic, such as some affective and anxiety disorders, flexibly bound groups offer long-term involvement in a familiar treatment setting.

Groups that combine psychotherapy and medication and which are more structured offer some advantages as well. Some examples of these include groups that combine CBT and medication for OCD or phobias, trauma-focused CBT and medication for PTSD, or groups using Interpersonal Therapy to address persistent depression.

A variety of formats may be used for groups focused on substance use as well. They may be closed or open, but are often time-limited. This will depend to some degree on the availability of community sobriety support groups

such as Alcoholics Anonymous and Narcotics Anonymous. It will also depend on whether members require medication "assisted" treatment.

In a large, urban primary care clinic, a psychiatrist and a social worker who visited the clinic weekly held an ongoing group for patients identified by their primary care physician as having significant depression. They had access to and documented their work in the clinic EMR and the social worker saw some of the patients individually at the clinic. This allowed patients to be offered specialty treatment within a week of their being referred, or as need was identified by the social worker who also functioned as a depression care manager at the clinic, and did the screening for participation in the group. Individual psychiatric appointments often took 4–6 weeks to arrange at a CMHC many blocks from the clinic, were not available to patients without Medicaid, and often appointments resulted in no-shows. The psychiatrist used the same E & M codes that the clinic used for other group medical visits.

Universalizing: Combating Stigma

Groups are destigmatizing. The group format allows the leader to poll the group, a technique called *universalizing*. For example, when a patient describes a problem, the leader can poll the group and ask who has had a similar problem, i.e., hearing voices, having suicidal thoughts, having a problem with alcohol or drugs, not taking medication, etc. When others including the leader indicate that they have had similar experiences, the member feels less stigmatized, less ashamed and the stage is set for an open discussion of that problem. Various techniques for coping with auditory hallucinations are frequently shared and the leader can offer alternatives to distraction and keeping busy such as talking back to the voices as if they were a nosey neighbor. A small randomized controlled trial found that group cognitive behavioral therapy reduces auditory hallucinations (McLeod et al. 2007). With a less intense relationship between members and the group leader, controlled staff disclosure is typically increased because it has less intense personal meaning than in a one-to-one session.

Go Rounds

By going around and checking in with each patient, the leader can address the problem of patients who don't talk and also of monopolizers who need to be contained (Stone 1997, 2000). But even with this format, feedback and discussion are encouraged. Patients do not have to talk at first and those who don't talk benefit from listening to others and feel encouraged to participate at their own pace.

Addressing Poor Adherence

The term "medication group" is often a misnomer since little time is actually spent discussing medication in most cases. Unless a patient is having a problem, medication is only addressed when prescriptions need to be renewed. Using medication properly is usually more important than the medication itself. In a periodic review of medication use the leader can ask, "How many times in the last week did you forget to take your medication, one? two? three?" Asking the question in this way normalizes nonadherence and facilitates an honest response. After hearing other patients admit that they did not take their medication as prescribed, it is easier to have an open discussion of this problem. If a person has only forgotten to take medication once or twice during the week, they can be praised for taking it most of the time. When nonadherence is a problem, it can be broken down into forgetting or not wanting to take it. Forgetting can be addressed in a variety of ways such as medication boxes, notes, convenient placement of medication, etc. Group members can give suggestions and share their successes. Developing a willingness to keep open communications about medicine is a long-term process which is facilitated by an ongoing, open-ended, group format.

The second reason for nonadherence, not wanting to take medication, must be addressed in

a nonjudgmental manner using motivational interviewing techniques and shared decision-making. Patients who have decided to stop taking medications can be encouraged to keep attending group so the outcome of this decision can be monitored and medication can be resumed quickly if need be. Group functions as a periodic wake-up call, reminding members that they need to take care of themselves. Many people with distressing symptoms need to work around their symptoms in their daily lives so that they can function. Conflicts and feelings may build up over time such that the outlet provided by the group can help them avoid becoming overwhelmed in their usual setting.

Individual Appointments

Group members should be told that they can have an individual appointment any time. They may rarely need to ask, but this availability can be reassuring. If they have something to say that is very personal and private, which they do not want to discuss in group, access to a more private outlet is appropriate. In many cases however, when asked "Is there some reason you could not say that in group?" most will recognize that they actually could have raised it in group. Nevertheless some patients prefer to discuss some things in private such as sexual problems, threatening thoughts or thoughts with otherwise disturbing content. *Vagueness* is a technique which can be used to discuss private material in group by using nonspecific labels for these problems.

> Joe was a high functioning man with bipolar disorder and a disturbing, disruptive addiction to internet pornography. Once his symptom has been disclosed privately to the psychiatrist, he could be monitored in group without disclosing what his symptom was by posing the question "How have you been doing with your 'time management' this week?"

There will be instances in which a group member does not use the group well, or is disruptive despite frequent interventions. In such cases, it is reasonable to suggest that the struggling individual take a vacation from group, and refer them for individual treatment until they are better able to use the group format.

Conclusion

Psychiatrist-led outpatient group treatment for patients across the spectrum of psychiatric disorders is more efficient, more fun, more stimulating and invigorating, for both therapists and patients, than individual treatment. Evidence suggests that group treatment is associated with better outcomes including retention in treatment, better medication adherence, fewer hospitalizations, and shorter hospital stays. Groups for patients with severe mental illness can provide psychotherapy, psychosocial rehabilitation, and medication management in a flexible, opened, one-stop-shopping environment, which can enhance medication adherence and provide a safety net for persons with mental illness and substance use disorders living in the community. Better recovery outcomes have been associated with group treatment including improved social functioning, better self-esteem, more self-assertion, better coping, and less hopelessness. Group is an underutilized modality which supports recovery with clinical evidence of effectiveness and which deserves further development.

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21 Family Therapy in Public Sector Settings

Alison M. Heru

Introduction

Family interventions improve outcome for patients with psychiatric illnesses (Heru 2006). This chapter identifies key aspects of evidence-based family interventions and shows, through case examples, how to implement family-based treatment in public sector settings. Family interventions develop family resilience, promote individual recovery, and prevent the development of illness. Resilient families have better outcomes for medical illness (Weihs et al. 2002) and psychiatric illness (Tienari et al. 2004; Miller et al. 2008; Keitner et al. 1995; Roberts et al. 2009).

Resilient families have strong affiliative values, and approach adversity as a shared challenge. Cohesion and connectedness provide mutual support and collaboration among members when a family faces a crisis. Clear, direct communication facilitates effective functioning, which facilitates problem-solving, an essential skill in times of adversity. The key family processes that contribute to family resilience occur in three domains: family belief systems, organizational patterns and communication/problem-solving (Walsh 2003). Enhancing family resilience is an important treatment goal and professionals can actively support the family in building resilience by providing opportunities for the family to be involved in the care of their relative.

Resilience is closely linked to the concept of Recovery, which emphasizes hope, supportive relationships, social inclusion, and active coping skills and sees psychiatric treatment as a partnership between clinician, consumer, and family. The American Psychiatric Association endorses the concept of Recovery and cites family interventions in their recommendations for treatment of major mental illnesses (American Psychiatric Association Work Group on Schizophrenia 2004, 2002; American Psychiatric Association Work Group on Depressive Disorder 2000). The Surgeon General's Report on Mental Health in 1999 (US Public Health Service 1999) concludes that mental health care should be consumer and family-oriented and should have Recovery as its primary aim. These recommendations are beyond the financial and organizational ability of many health care systems. However, in Pennsylvania, a new entity called the Pennsylvania Psychiatric Leadership Council (PPLC), established by the Pennsylvania Office of Mental Health and Substance Abuse Services in 2005 has incorporated many family principles into its mission.

In Pennsylvania, the PPLC has established three public psychiatry fellowship training programs (see Chap. 48) dedicated to providing fellows with family-oriented training opportunities (Mannion et al. 2011). The fellowship training in these programs engages family support organizations, includes family members as faculty in trainee

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education; and addresses the limitations in trainees' previous education in family work. Innovative ways are found to involve the family. For example, during the "15 min med check," the fellows introduce themselves to family members and schedule appropriate meetings with the consent of clients. The fellows are offered leadership opportunities in anticipation of being able to influence policies on family inclusion, are encouraged to speak at community events and serve on expert panels. Clinics are welcoming and spacious with family-friendly environments and offer flexible appointment times to accommodate families. Most importantly, the behavioral health systems in the Philadelphia region improved reimbursement so that face-to-face contacts with family members are reimbursed at the same rate as client clinical encounters.

Examples of family-based programs can be found throughout the USA. A family-oriented recovery program for children called "wraparound" provides mental health and community services individualized to each child and family (Hinden and Wilder 2008). The wraparound process builds on family strengths, and is coordinated across several agencies. The families and children set their own goals and their preferences guide treatment. Frequently there is a paid family support specialist from a similar cultural background as the family, to help engage the family. Informal community supports include extended family, friends, the faith-based community, boys and girls clubs, teachers, and neighbors. An ultimate goal of wraparound is to replace formal supports with informal supports, thus enhancing family resilience.

Despite these efforts, many people in need of services will not attend mental health clinics citing pathologizing labels and a focus on individual symptoms. Such was the case with Bosnian and Kosovar refugees who ultimately benefitted from a community-based family resilience approach. Families readily participated because it tapped into family-centered cultural values and was held in a storefront in their neighborhood. The families shared stories of suffering and struggle. The 9-week treatment affirmed strengths, resources, strong kinship networks and recognized the families' determination to rise above tragedy and forge a new life. The families were encouraged to bridge cultures, sustain kinship ties, and find a way to belong to both old and new worlds. Facilitators from the community were trained to co-lead the groups thus fostering collaboration and the development of local resources (Walsh 2007). A family resilience perspective focuses on strengths and coping skills rather than deficits and psychopathology.

How Psychiatrists Can Incorporate Family Resilience into Their Practice

Adopting a family resilience approach means stepping back and looking at the patient's environment and thinking about the family system. Here are six key questions to ask about the family:

1. Who in the patient's life constitutes family? This might include close neighbors, friends, involved family who live at a distance, a case manager, AA sponsor, etc.
2. What is the developmental stage of the family and how does the family manage transitions? In brief, family stages are marriage, birth of a child, middle stages (parenting, work, adolescent maturation, caring for elderly family members), retirement, illness, and death. Has the patient's illness caused a delay or disruption in the normal progression of one stage to the next? Are there factors such as immigration, cultural differences between members, blended families that might cause difficulties with transition through stages?
3. Have there been family role changes due to illness? If the ill family member is the wage earner, how is the family getting an income? An ill child or a teenager causes family disruption but provisions can usually be made for care without a change in the family structure. A grandparent who gets ill may need to be taken into the house. A young adult may need to return home or may never be able to move out. A single parent with mental illness may have difficulty providing care for children and may return to the parental home, to a relative's home or become homeless.
4. How are the children developing? Are any children in need for support or intervention?

Would parenting classes or increased parental support be helpful?

5. Does the family know about community resources? Can the family access ALANON, NAMI, MDNA, or online resources such as *familyaware.org*?
6. What does the family want? What is their perspective? Understanding the family's perspective helps the psychiatrist develop empathy for the family and a stronger alliance.

Engaging Families in Treatment

Engaging families means listening and understanding the experience of the family. Patients and their family members may attribute schizophrenia to family factors such as hostile or rejecting parents, too high parental expectations, father being too severe, or mother being overprotective (Broussard et al. 2010; Angermeyer and Matschinger 1996). In one study (Broussard et al. 2010), 63.9% of respondents reported at least one family factor and 44.3% reported more than one family attribution factor. Fifty per cent also reported a belief that possession by spirits, pollution, radiation and punishment from God contributed to schizophrenia. An empathic family interview can identify and discuss these beliefs and allow for alternative explanations to be put forward by the psychiatrist.

If you are unfamiliar with the culture and cultural expectations of the family, asking the family questions about their culture engages them respectfully. We also may assume, inaccurately, that we understand the experience of American families, when in fact we may have little knowledge of the stresses and strains of everyday life, especially poor families. The risk for depression in families facing multiple adversities is high, and underutilization of mental health services by urban families of low socioeconomic status is well documented and concerning. The stigma of mental illness then becomes confounded by deprivation and adversity.

What can we learn from patients about how to overcome these barriers? Sixty per cent of low-income women bringing their children for behavioral health care, met criteria for depression or anxiety (Anderson et al. 2006). They were reluctant to enter treatment because they saw their distress as a normal response to stress, to the daily hassles of poverty, past and/or current abuse, and the stress of managing a disturbed child. These women agreed that they were depressed or anxious, but resented labels suggesting that the distress was internal to them. Many of these women believed that the system would not make a distinction between manageable and unmanageable depression and that their children might be taken away. Despite their fears, most mothers were involved in their child's treatment. The mothers indicated, however, that few clinicians asked them how they themselves were doing, leaving the impression that their problems were irrelevant. The women perceived therapists as too naive or inexperienced to appreciate their life difficulties. A family approach that allows mothers to share their world views and life experiences, will help women improve their own and their child's mental health.

One such family-centered intervention for parental depression enrolls parents when they present with their children (Podorefsky et al. 2001). Parents described their experience of depression as a reaction to traumatic and chronic stressful life events. Interventions are contextualized within this framework. Family resilience is developed by encouraging activities outside the home, developing a deeper self-understanding and stronger relationships in the community (Beardslee et al. 2003). This program has also been adapted for use with Latino families (D'Angelo et al. 2009), using bilingual and bicultural providers to promote the family intervention. History-taking is expanded to include stories about immigration and the complexities of adapting to a new culture. The family meeting facilitates the creation of a shared understanding of the family experience of parental depression, and for many families, this is the first time they are having a family conversation about issues such as the impact of immigration, family separation, and the loss of traditional support networks.

Many parents with serious mental illness have concerns about parenting but are reluctant to voice these concerns due to fear of being seen as incompetent and having their children removed

from the home. Resources such as parenting classes or educational literature about mental illness for their children can be offered to all patients who are parents. Good parenting is protective, even in the presence of severe adversity such as parental mental illness. Parenting quality was an independent predictor for competency in 205 children and adolescents ($p < 0.001$) in a 10-year study assessing academic achievement, conduct, and peer social competence. Structure, rules, closeness, warmth, high expectations for the child's achievement and prosocial behavior were the key parenting qualities (Masten et al. 1999). Children want information about their parent's illness and identify that an understanding of psychiatric illness relieves self-blame. There are also strong benefits from improving social connectedness for these children (Fraser and Pakenham 2009).

The Family Meeting

A family assessment can be modified depending on the presenting problem. In the emergency room, a family assessment focuses on the family's ability to communicate and problem solve about safety. It is easier to include more family members earlier in the treatment process than later. Family members are more likely to mobilize around a crisis and make an effort to put aside their own issues to deal with the crisis, as opposed to after the situation has settled. Small children can contribute a great deal to a family meeting. Parenting skills are assessed by noting if parents bring toys, food, or other supplies to a meeting and if parents can work together successfully to manage the children in the meeting. For example, if one member is talking, can the other member help by engaging the children in an activity? Children can answer simple questions: How does daddy feel most of the time? How does mommy feel? What makes you feel sad? What makes you happy? Some children may blame themselves: If I behaved better then mommy would feel better. Simple interventions such as reassurance, at this stage, can prevent difficulties at a later time.

A family meeting starts with an orientation and acknowledges that family members have important activities and responsibilities that they have put aside to help with treatment. The process of the meeting is normalized with an explanation that family meetings are a regular part of the assessment and treatment for all patients. The family is asked what they expect and what they would like to get out of the meeting. The psychiatrist summarizes their answers to make sure the family knows that they had been understood. A common introduction is: "Thank you all for coming in. We like to meet with the families of all of our patients. This is an opportunity for you to let us know how you see the problems and to raise any concerns you may have. You will have a chance to ask any questions. Finally, this will be an opportunity for all of us to put our heads together in order to determine what the best treatment plan is. Is that all right with you?"

The family is asked to identify what they see as the problems in the family. The psychiatrist should spend enough time with each family member to ensure that he or she has an opportunity to outline their concerns. The challenge for the psychiatrist is to not get sidetracked before everybody has had an opportunity to present their perspectives. The psychiatrist has to make sure that the problems are described in adequate detail but not take up too much time. The psychiatrist can remind the family that the initial goal is to develop a problem list from all family members. Listening carefully, summarizing and giving everyone the opportunity to speak without interruption allows for the development of an overview of the problems and reassures the family about the fairness of the psychiatrist and the process.

Assessing family functioning across several dimensions ensure a comprehensive and consistent evaluation. Problem-solving, communication, roles, behavior control, affective involvement and affective responsiveness are six dimensions from the McMaster Model of Family Functioning (Keitner et al. 2009). Table 16.1 outlines typical questions to complete a family assessment (Table 21.1).

Table 21.1 Dimensions of family functioning

Problem-solving: The ability to resolves problems to maintain effective family functioning. Instrumental problems are problems of everyday life, such as managing money, obtaining food, clothing and housing, and affective problems concerning emotions such as anger or depression. Families whose functioning is disrupted by instrumental problems rarely deal effectively with affective problems. Stages of effective problem-solving are as follows: identification of the problem and communication of the problem with an appropriate person, developing alternatives, deciding on an alternative, acting upon that decision, and monitoring outcome
Questions: Who first notices problems? What did you do after you noticed the problem? Did you discuss it with anybody? What did you decide to do about the problem? Did you think of any alternatives? Did you discuss how you dealt with the problem once you had taken care of it? How do you handle practical problems? How do you handle emotional problems?
Roles: How the provision of resources, nurturance and support, sexual gratification, personal development and maintenance and management of the family system are divided between members, including decision-making, boundaries, household finances and management
Questions: Who works and for how many hours? Who handles the money? Who buys the groceries and prepares the meals? Who looks after the home and cars? Who oversees what happens with the children's education? Who is involved in major decisions and who has the final say? Do any of you feel overburdened by your jobs? Are the responsibilities fairly shared between family members? If not, how would you like to see it done?
Communication: The verbal exchange of information within a family. Families can have marked difficulties with the affective component of communication but can function very well in the instrumental area. Communication can be clear or masked (camouflaged). Communication can be direct or indirect (comments delivered to someone else rather than the intended person)
Questions: Do people in this family talk with one another? Can you talk about practical things with each other? Can you talk about emotional issues with each other? Do you feel that you can talk things through with others in the family, or do you have to be guarded about what you say? Can you tell things to each other directly, or do you go through someone else?
Affective involvement: How the family shows interest in and values the activities of other family members. Families who lack involvement with each other merely coexist in the same space without connection. Family members who are narcissistically involved are invested in others only in terms of what they can get, without real concern for others. Empathic involvement means that family members demonstrate true concern for others, even though these concerns are peripheral to their own interests. Overinvolvement and symbiotic involvement are overintrusive, overprotective, with blurred boundaries between family members
Questions: Who cares about what is important to you? Do you think other family members are interested in you? Do they ever show too much interest? Do you feel that they are truly interested in you because it is important to you, or only because they think they should be? Do you feel that other members of the family go their own way and do not care or notice what happens to you?
Affective responsiveness: Ability to respond with a full range of feelings, and whether or not the emotion experienced is consistent with the context. Welfare emotions consist of affection, warmth, tenderness, support, love, consolation, happiness, and joy. Emergency emotions are fear, anger, sadness, disappointment, and depression
Questions: Are you a family that responds to situations with a lot of feeling? Do any of you feel that you are a family who underresponds in terms of emotions? Which kinds of emotions do you think you over- or underrespond to? Are there any feelings that you experience more intensely than reasonable given the situation?
Behavior control: How a family establishes rules about behavior, such as parental discipline, and standards and expectations of behavior that adults set for each other. There are several styles of behavior control: rigid behavioral control, flexible behavior control, laissez-faire behavior control (where there are no standards or direction), and chaotic behavior control where standards shift in a random unpredictable fashion
Questions: Do you have rules in your family about how to handle different situations? How do you handle dangerous situations? Do you allow hitting or yelling at each other? Do you know what is expected of you in terms of behavior with people outside the family? Do you have rules about drinking? Driving too fast? Letting people know where you are when you are away from home? Are the rules clear? Are the rules the same for everybody? Can you discuss the rules to change them? Do you know what to expect if the rules are broken?

Adapted from Keitner et al. (2009)

Family Treatment

The following case examples show how family assessment and family therapy can be incorporated into a psychiatric assessment and treatment.

Ms. Talia

Ms. Talia is a 37-year-old, Hispanic woman with morbid obesity, obstructive sleep apnea and asthma. She presents with anxiety and panic attacks. She has a past history of substance abuse and has been in prison for drug-related crimes. She is receiving disability. Her family constellation consists of four teenage sons in her mother's custody. Her sons live between her house and her mother's house. A young girl baby, who is the child of her niece, is living with the patient. The niece, who is actively using substances, sometimes stays with the patient and sometimes disappears for weeks. A boyfriend also sometimes stays with her. Ms. Talia wants custody of the baby girl and presents in the clinic asking for help with her psychiatric symptoms so that she can be well enough to go to court to get custody.

Family assessment with Ms. Talia and her mother

The psychiatrist met with the patient and the mother and completed the family assessment over several routine visits. The first visit was 1 h and the following visits were 20 min. Medication management also occurred in the treatment sessions.

Problem-solving

Ms. Talia relies on her mother to help with all problems. She states that she would like to be more independent but does not know how. The mother supports her goal.

Communication

The mother and the daughter do everything together. Ms. Talia shares all her thoughts and feelings with her mother. The mother does not share her thoughts with the patient and says that she "just wants to help." The mother is not critical and says, "It is my duty as a mother to help."

Affective involvement

Overinvolvement, and associated guilt on the part of the patient for depending on the mother. The mother accompanies her to all appointments, grocery shopping, etc. The mother acknowledges her overinvolvement but says, "It is my duty to help."

Affective responsiveness

The patient is anxious most of the time. She experiences pleasure with her baby girl in the house, dressing her and changing her outfits many times a day. The mother thinks she is obsessed with the baby and she treats the baby like a doll. The patient cries and feels overwhelmed a lot and guilty because she depends on her mother for money and emotional support. The mother experiences a normal and full range of emotions.

Roles

The mother and the daughter spend most of their time caring for children, theirs and children of extended family. The mother, although on a fixed income, provides as much financial support as possible for her daughter. Her daughter is on a fixed income but gives away food and money to other family members and her boyfriend.

Behavioral control

There are no house rules. It is unclear from appointment to appointment who is living in Ms. Talia's house. She is thinking about setting rules about substance abuse and throwing her niece out of her house but is not able to because "there is nowhere for her to go."

Case formulation

Ms. Talia has GAD, panic disorder, personality disorder with dependent and histrionic traits and a significant past history of substance abuse. Her family assessment reveals an overinvolved relationship with her mother and a chaotic living situation. Family strengths are caring of others and their self-identification as strong good mothers. Ms. Talia and her mother agree with the

formulation. The mother and the patient agree that Ms. Talia needs to set limits with the niece and her boyfriend and tell them they cannot stay there if they are "high" or "crashing." She agrees to tell family members and her sons, that she can no longer give them money, when she herself does not have enough for groceries. She says that although she agrees and knows she needs to do this, she cannot, because she "feels bad for other people." The mother, supported by the psychiatrist, takes the stance that while this is an admirable and valued family trait, she will not get better and thus will not be able to get custody of the baby girl unless she sets limits and controls her home environment. Ms. Talia asks for medications to help her. The psychiatrist agrees that medications are part of the plan but that the patient needs to do her part and set up house rules. The mother and the patient agree.

At each meeting the plan is reviewed. Eventually Ms. Talia puts out the freeloaders and sets family rules for those who remain in her house. Ms. Talia reports that her level of anxiety and panic has not changed but she is feeling better now that she has some control over her life. Monthly visits with the patient and her mother set goals such as the patient taking her citalopram 20 mg, as prescribed and keeping all her medical appointments. She also sets general health goals such as healthier eating and more exercise to try to avoid frequent hospitalizations for asthma attacks.

Learning points

There are many potential interventions for Ms. Talia. The family assessment approach pinpointed family strengths that can be used in treatment: her relationship with her mother, strong mothering qualities and her desire to care for the girl baby. The patient's relationships have unsettling elements, e.g., dressing up the baby girl and overinvolvement with her mother, but focusing on these deficits may result in alienating the patient and her mother. Medication administration is incorporated into a larger contract with the patient and her mother. Without a family assessment, the strengths and weaknesses of the family system would not have been evident. The recommendations are framed in a family context with an emphasis on family strengths.

Mr. Cadie

Mr. Cadie is a single 50-year-old man who lives alone and has diagnoses of bipolar disorder and alcohol dependence. His neighbors called police because he was outside yelling at midnight. He was admitted to a medical floor with uncontrolled diabetes, alcohol dependence, and metabolic syndrome. He was transferred to a psychiatric inpatient unit where he voiced angry feelings towards his mother for betraying the memory of his father who had died 4 years ago. A case manager and his 75-year-old mother, Mrs. Zabir, are his only social contacts. His mother is well, works part time and recently remarried. She visits her son but expresses fear of him since he threw the phonebook at her a month ago. The outpatient psychiatrist arranges to meet with the family and case manager to develop a treatment plan.

Family assessment with Mr. Cadie, his mother and stepfather, case manager and psychiatrist

The meeting, which was scheduled for 1 h, begins with the stated goal of developing a treatment plan for Mr. Cadie. Each family member is asked to identify problems. Mr. Cadie says that he does not want any contact with his mother. Mrs. Zabir says that she wants her son to have good medical care. Mr. Zabir says that he wants to be able to help Mr. Cadie in any way that he can. The case manager asks about medical problems and expresses concern about treatment compliance especially with his diabetic medication.

Problem-solving

When sober, Mr. Cadie has good and adequate problem-solving and takes his medication reliably.

Communication

When sober, all agree that he communicates adequately.

Roles
His mother pays all his bills and all are happy with that role. In terms of other roles such as social contact, friendships, and relationships, all agree that Mr. Cadie has become isolated and socially less competent and now frequently abuses alcohol.

Affective involvement
The patient is more isolated since his father died and his mother is more involved with her new husband.

Affective responsiveness
The patient is angry with his mother and sad about the loss of his father. Mr. Cadie used to spend time with his father and misses him a great deal. His mother is afraid of him; her husband is unsure of the situation.

Behavior control
Adequate when Mr. Cadie is sober.

Case formulation
All agreed with the assessment and the following problem list was generated.

1. Mr. Cadie has significant challenges getting his health care needs met.
2. Alcohol abuse is a result of his social isolation.
3. Mr. Cadie needs new social contacts.
4. Mrs. Zabir has a new life and wants to have less involvement with her son. She is afraid of him when he has been drinking.
5. Mr. Zabir is unsure how much he wants to be involved with Mr. Cadie.

The psychiatrist facilitates a family discussion about problem resolution. The family decides that a good intervention is to have Mr. Zabir drive Mr. Cadie to AA meetings three times a week. Mrs. Zabir will wait to hear from her son when he next wants to talk with her. She will not visit him at his home. If her son wants to talk to her, they will meet in a neutral place such as Jo's Diner. (This place was chosen by Mr. Cadie as he had fond memories there as a child with his parents.) The case manger suggests that Mr. Cadie call his brother who is out of state to talk on the phone once a week. (The case manager has in mind a possible transfer of medical power of attorney to Mr. Cadie's brother.) A follow up meeting is arranged for 1 month.

Learning points
The family relationships have to change after Mr. Cadie threw a book at his mother. A family approach allows the family to renegotiate their own relationships with the guidance of professionals. This family assessment and intervention is proactive with the goal of preventing future deterioration of the patient, encouraging sobriety, and reducing isolation and allowing, if necessary, for a transition of power of attorney to another family member.

Ms. Sharon and Ms. Anna

Ms. Sharon presents with anxiety symptoms and requests benzodiazepines. She is new to the clinic and states that she has been treated in the past for PTSD and has had several hospitalizations. She lives with Ms. Anna whom she describes as her caregiver. You ask her to bring Ms. Anna to the next appointment. At the next few appointments, you find out that Ms. Anna has significant depressive symptoms, is an undocumented immigrant, and is afraid of being deported. Ms. Anna has an excessive workload but is afraid to complain for fear of losing her job. Ms. Sharon is on disability. Both women express suicidal thoughts and want to figure out how to support each other better. A 1-h family assessment meeting is scheduled.

Family assessment

Problem-solving
They each identify problems but do not communicate or try to solve them together.

Communication
Poor for both emotional and practical issues.

Roles
Both contribute to the household for rent and food. They are in an intimate and caring relationship that they both find satisfying.

Affective involvement

They rarely go out together because Anna's work schedule is grueling. They spend their free time together and have few outside friends. They both are happy with this.

Affective responsiveness

They have warm caring feelings for each other but do not share these feelings with each other. They share general fearfulness about Anna being potentially deported. They each have intermittent suicidal ideation, which they do not communicate to the other.

Behavioral control

They engage in secretive suicidal and self injurious behaviors from time to time. They would like to change this.

Case formulation

Both Ms. Anna and Ms. Sharon agree with this assessment and want to work on improving their relationship. As the psychiatrist, you are most concerned about their suicidal ideation and self injurious behavior and work on developing a mutual safety plan. In following appointments, they work on spending quality time together, accepting that their relationship is strong but always in danger due to possible deportation. They work on improving their communication, problem-solving, and sharing more positive feelings.

Learning point

Although this couple cannot change the circumstances of their lives, they can reduce acting out behavior and improve the quality of their relationship.

Conclusion

Many psychiatrists recognize that a narrow approach to psychiatric illness does not yield optimal results. Working with the family improves patient outcome. "Thinking Family" means listening to family members when they call with a question, even if the patient has not signed a release. Confidentiality means stating that you cannot discuss patient specifics but that you can listen and provide general information on how to handle emergency situations, usual side effects of medication and medical symptoms. A family meeting is key to understanding the patient in their family context. Residents often take No for an answer when the patient says that the family cannot come to an appointment and residents should be encouraged to gently insist on meeting with the family. For residents, thinking about the family and involving them in the initial patient assessment is an easy first step. When families are difficult to understand or when the assessment process gets bogged down or when the psychiatrist feels unsure of what to do, then seeking supervision or a referral to an experienced family therapist is appropriate. Most families appreciate being involved and will work hard to help you help their family member.

In the larger health care system, the psychiatrist can advocate for the patient and family. Psychiatry can advocate for the routine involvement of families in psychiatric assessment, decision-making, and treatment planning. Psychiatry can promote a clinic that is family-friendly, supporting connection and involvement, and develop multifamily support groups (Tienari et al. 2004; Miller et al. 2008; Keitner et al. 1995). Educational literature can be available to all family members and offered in several languages. Resources can be provided in the clinics and may include a list of books written for families such as Michelle Sherman's I'm Not Alone: A Teen's Guide to Living with a Parent Who Has a Mental Illness (Sherman and Sherman 2006). The World Fellowship for Schizophrenia and allied disorders Web site (http://www.world-schizophrenia.org/resources/booklist.html) has a list of recommended books for patients and their families. Families can be supported in their desire for information and given help to access additional services such as transportation, parenting classes, learning English as a second language, etc. Psychiatry must recognize the important contribution that family advocacy brings to the health of all family members increasing family and individual resilience, which in turn prevents illness in family members.

Partnering with community organizations reduces barriers between patients, families and psychiatry. Organizations such as NAMI, DBSA,

AA, NA, and ALANON are powerful allies in the fight to identify and treat psychiatric illness. Psychiatrists are popular speakers at community conferences, providing family members with understanding and clear direction about managing psychiatric illness in the family. Most important, however, is our need to partner with families. Family members of our patients have changed how the community and the profession view psychiatric illness by initiating and pushing the Recovery movement. We owe it to families to include them at all levels of care, especially decision-making and treatment planning.

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22 Basic Treatment Techniques for Persons with Mental Disorders and Co-occurring Substance Use Disorders

Richard N. Rosenthal

Introduction

Chapter 23 details the psychopharmacology and psychosocial evidence base for treating co-occurring of mental illness and substance use disorders (COD).This chapter focuses on a basic level of practice: basic techniques that underlie the common clinical approaches that community psychiatrists and other clinicians use in treating patients with COD. This focus on technique does not describe new interventions for COD, or describe standard treatment approaches, but rather offers a clinically oriented way for clinicians to think about them, so that there is a menu from which they might be more easily implemented.

Definitions

Techniques are clinical interventions that are situated within a conceptual hierarchy of increasingly complex behavior, from the basic skills through complex clinical strategies. These are defined below. *Skills* are the basic clinical abilities to listen to patients, ask open-ended questions, assess acute risk, maintain professional boundaries, develop differential diagnoses against a knowledge base, etc. Developing competence in these basic skills is prerequisite for clinicians wishing to implement techniques to treat COD. *Techniques*, the main focus of this chapter, are how the clinician uses these skills to achieve a specific outcome, such as to establish a therapeutic alliance, to manage intoxication, or to facilitate treatment adherence.

Tactics are the clinical decisions about the method and timing to implement specific techniques, since patients are differentially receptive to techniques depending on various characteristics such as motivational stage, severity of psychopathology, cognitive functioning, and living environment. Tactics are therefore stage-specific and graded, since patients will be most receptive to various techniques at certain times and with specific intensities. For example, cognitive behavioral relapse prevention operates on the assumption that the person is motivated for change. If those techniques are applied to someone in a precontemplation stage (not yet interested in changing behavior), they are likely to have less efficacy than if they are applied after several sessions of motivational interviewing, which have brought the patient into a stage of contemplation (thinking that there may be a problem) or preparation (has decided to change). In the case of an integrated approach to substance use disorders (SUD) and co-occurring posttraumatic stress disorder (PTSD),

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the evidence suggests that the tactic of first stabilizing the SUD through the teaching of cognitive behavior therapy (CBT)-based sobriety skills improves outcomes of exposure therapy for PTSD (Back et al. 2009; Coffey et al. 2005).

Strategies employ tactics to achieve a specific clinical goal. Motivational Interviewing is a clinical strategy to increase the patient's readiness to change his or her behavior, where, for example, the therapist uses skills such asking open-ended questions and providing nonjudgmental feedback to implement the technique of reflective listening. *Strategies* are the art of employing tactics and techniques to achieve a specific clinical objective—e.g., Motivational Interviewing (MI), with its of application of rolling with resistance and developing discrepancy (techniques) with a patient in the preparation stage (a tactic) to effect the decisional balance, such that the person decides to set a date for abstinence (see Chap. 17 for a detailed discussion of MI). Typically known as a named therapy, (e.g., cognitive behavior therapy [CBT], motivational enhancement therapy [MET]), a *treatment approach* codifies, usually through manualization and clinical trials, a set of clinical techniques, tactics and strategies into a cohesive, internally consistent set of behavioral interventions for specific clinical problems.

Basic Concepts

Treatment Techniques Differ from Evidence- or Consensus-Based Practices

Techniques are the main clinical procedures that clinicians use to conduct treatment. In addition to those used in evidence- and consensus- based approaches to COD care, there are many techniques that are in use by clinicians for treating COD, which have not been formally examined through high-quality research or expert consensus panels. It is important to note that all treatment approaches (e.g., CBT) and treatment strategies (e.g., preventing relapse to substance abuse) rely upon clinical techniques for implementation, but that it is the approaches and strategies that are typically tested in clinical trials, not the core techniques. Nonetheless, and critically, many of these techniques are the content of day-to-day interactions that community psychiatrists interested in treating COD should know.

Evidence-based practice is the use of current and best research evidence in making clinical and programmatic decisions about the care of patients (Rosenthal 2004). These practices typically rely upon a specific set of well-described techniques. The scope of evidence-based practices ranges from a single focused strategy or technical style (e.g., Motivational Interviewing, Brief Intervention) to a full program model that uses multiple techniques (e.g., Assertive Community Treatment). Consensus-based practices are those that have clinical or expert consensus support, but lack a well-documented scientific evidence base. For many, distinguishing between techniques and treatment approaches (therapies) can be confusing. For example, although both are evidence-based practices, the strategy of motivational interviewing is a brief focused technical style (Miller and Rollnick 2002), whereas MET is a manualized, multiple-session *treatment approach* grounded in the transtheoretical stages of change model (Prochaska et al. 1992) that includes motivational interviewing as one of its core strategies, in addition to enlisting supportive techniques such as affirmation, and family techniques involving a significant other such as establishing rapport, eliciting feedback, and promoting family cohesion (Miller et al. 1992).

Treatment Techniques Differ from Skills, Tactics, and Strategies

Treatment techniques form the core of therapist's interventions with patients with COD. There are techniques generally applicable to patients needing mental health or substance abuse services and also more specific techniques that are more directly applicable to those with COD. There are also techniques that the clinician uses to interface with people and systems outside of the patient,

for his or her benefit. The American Psychiatric Association (2006) practice guidelines for treating SUD include a section on psychiatric management, which includes treatment strategies that are supported by various treatment techniques. Each of the following engagement, psychosocial, and medical treatment strategies can serve as a platform for the clinician to organize techniques from different sources and traditions that are critical for the treatment of COD (Table 22.1).

Engagement Strategies

Establishing and Maintaining a Therapeutic Alliance

The techniques that support the development and preservation of a therapeutic alliance are instrumental to the conduct of COD treatment (CSAT 2005). Without this alliance, which for patients includes elements of trust, rapport, faith in the clinician's abilities, and agreement on treatment tasks and goals, it is more difficult for the clinician to obtain the most complete diagnostic and treatment-related information (Safran and Muran 2000). In general, an early and strong therapeutic alliance is predictive of positive outcome in psychosocial treatment and decreased drug use in patients with SUD (Conners et al. 1997; Westerman et al. 1995; Winston and Winston 2002).

Specific clinical techniques that facilitate the development of a therapeutic or working alliance are as follows: maintaining a stance that is respectful, welcoming, accepting, warm, empathic, hope-inspiring, confident, nonjudgmental, trustworthy, and open; setting appropriately frequent patient contacts; listening reflectively; providing accurate feedback and interpretation; setting appropriate limits; being sensitive to the person's ethnic identity and cultural values and beliefs; and being a good role model (Ackerman and Hilsenroth 2003; CSAT 2005; Misch 2000). Empathic attunement with the patient's internal state is affirmed when the clinician provides empathic feedback and validation, which sustains and deepens the patient's experience of being understood (Gabbard 2000). However, even simple interest in the patient helps the therapeutic alliance, with clinical benefits. In a study of recently detoxified primary care patients, care by clinicians who had more knowledge about the patient (medical history, home/work/school responsibilities, health concerns, and values and beliefs) predicted lower drug and alcohol severity on the Addiction Severity Index and decreased odds of future substance use (Kim et al. 2007).

A critical technique to reduce the risk of a rupture in the therapeutic alliance is for the clinician to manage his or her countertransference feelings so as to avoid arguing, which evokes resistance (Miller and Rollnick 2002) and has a negative impact on therapeutic outcomes (Henry et al. 1990; Winston et al. 2004). The clinician manages countertransference through the skills of becoming aware of strong reactions and biases toward the patient (such as anger, pessimism, or critical thoughts) that may be impeding the therapeutic work, and then obtaining appropriate clinical supervision to troubleshoot specific problems, as well as participating in periodic formal supervision and team meetings to discuss general countertransference issues (CSAT 2005).

In addition, techniques to resolve conflicts between patient and clinician are also critical to maintaining the therapeutic alliance. These are as follows: first addressing the problem practically in the context of the current situation; clarifying misunderstandings; expressing sincere regret at having unwittingly impugned or patronized the patient; supporting the patient's ability to express disagreements in the context of an ongoing therapeutic relationship; and maintaining flexibility in one's position or on the current tasks when the patient is becoming angry or distant (Bond et al. 1998; Safran and Muran 2000). If a misalliance is not resolved first through approaching the patient's complaints and concerns with a practical discussion, then the clinician should move tactfully into a discussion of potential problems in the working relationship (Rosenthal 2008).

At times, confrontation can be an appropriate technique to demonstrate to the patient the reality of his or her minimizing, evasive, blaming, rationalizing, or denying behavior, but it must be pursued with a strong awareness on the part of the

Table 22.1 Therapeutic approaches and related key techniques for COD patients

Approach	Core technique	Purpose
Motivational interviewing	Express empathy through reflective listening and acceptance	Demonstrates clinician's acceptance of patient's ambivalence to change
	Develop discrepancy between current behavior and patient's own goals	Shifts decisional balance towards change and healthier behavior
	Roll with the resistance by offering new information and perspectives	Supports the patient's autonomy and decision-making process
	Support self-efficacy through engaging demonstration of patient's strengths and capacity to change	Supports patient empowerment to take responsibility for recovery process
Supportive psychotherapy	Form and enhance the therapeutic alliance through expression of interest, empathy and understanding, judicious self-disclosure, and purposive repair of misalliances	Increases treatment engagement and exposure through facilitated strengthening of the therapeutic alliance
	Enhance self-esteem through direct measures such as reassurance, praise, reframing, and encouragement	Decreases demoralization through improved self-efficacy and belief in possibility of change
	Improve adaptive skills through teaching, anticipatory guidance, modeling, and problem-solving	Increases personal and interpersonal functioning to improve quality of life, and perceived competence
	Restore or improve psychological functioning by supporting adaptive defenses and reducing anxiety	Improves mechanisms for coping with stress, impulsivity or dysphoria and improves resilience
Cognitive behavioral relapse prevention	Conduct a functional analysis for each drug use episode to identify thoughts, feelings, and circumstances before and after drug use	Improves understanding of reasons for use and recognition of situations in which the patient is most likely to use, so the patient can avoid them when appropriate
	Provide skills training to unlearn drug abuse-associated habits and learn/relearn healthier skills (effective coping skills may never have been learned, may have decayed with reliance on substances for coping, or may have been weakened by co-occurring psychiatric disorders)	Improves patient's coping effectively with a range of substance-associated problems and behaviors
	Alter the contingencies of reinforcement. Since substance use excludes other experiences and rewards, identify and reduce drug-associated habits by substituting positive activities and rewards	Supports acquisition of healthy pleasures
	Teach techniques to recognize and cope with urges to use, a model for learning to tolerate other strong affects	Fosters overall management of painful affects
	Provide interpersonal skills training and strategies to help patients expand their social support networks and build enduring, drug-free relationships	Improves interpersonal functioning and enhance social supports

(continued)

Table 22.1 (continued)

Approach	Core technique	Purpose
Motivational enhancement therapy	Identify the patient's current stage of change	Allows therapist interventions to be *in synch* with the patient's motivational state, thus more likely to be effective
	Elicit self-motivational statements	Elicits the patient's intrinsic motivation to tip the decisional balance about change
	Use reframing to cast patient own statements about their behavior in a new light	Allows the patient to hear that problems are addressable and changeable
	Engage significant other in the recovery process by joining, normalizing, and eliciting feedback and support for the patient's intrinsic motivation for change	Allows the patient to obtain social support and collaboration for the work of recovery, and promotes family cohesion
	Provide formative and summary feedback of patient statements during a session	Allows patient to hear reinforcing self-motivational statements several times during and at the end of a session
Substance abuse management module	Stop before a slip becomes a relapse; report a slip to a support person	Patient learns to practice damage control and reduce the abstinence violation effect
	Recognize warning signs and make U-turns; learn money management; remove triggers, ride out craving, report side effects	Patient learns to avoid high-risk situations, including tolerating strong affects
	Model and role-play refusing drugs from an aggressive dealer, a friend or relative	Patient learns to escape high risk situations
	Identify healthy pleasures, and practice asking someone to join in	Patient learns to seek healthy pleasures, establish healthier habits and schedule, reinforce social connections
Contingency management	Arrange for regular, reliable and valid assessment of a selected target behavior, e.g., testing for substances	Operationalizes to patient and clinician a specific and neutral means to measure behavior
	Find appropriate reinforces and provide them after target behavior is demonstrated, e.g., sobriety, medication adherence. Add bonuses cumulatively	Applies behavioral principles in a way the patient finds rewarding: e.g., cash, vouchers, prizes, privileges
	Withhold incentives when target is missed, e.g., positive test for substance	Applies behavioral principles to shape behavior the patient agrees is unwanted
	Work with patient to establish alternative, nonrisky behaviors	Expands behavioral repertoire, with positive impact on self-esteem
Twelve-step facilitation	Foster patient's acceptance of substance dependence as an illness characterized by loss of control and chronicity	Supports patient's adoption of a belief system conducive to engagement in 12-step recovery
	Foster patient's surrender to some power outside of the self, since loss of control is a reality and 12-step fellowship has helped millions with the same problem	Supports the patient's exercise of a decision and commitment to accept external help and imparting of hope
	Foster commitment to AA: not only to show up at meetings but to engage in the AA program	Supports the patient's ability to engage in the active and intrinsically rewarding work of recovery
	Find and use meetings that the COD patient can feel a part of, the "right" meetings	Supports the COD patient to optimize the meetings attended so that resistance is lowered
	Identifying substance use relationship to patterns of thinking, feeling and behavior	Patients learn to identify cognitive and emotional triggers to use and to use social contacts to support sobriety

Adapted from CSAT (2005); Higgins and Petry (1999); Miller et al. (1992); Miller and Rollnick (2002); Nowinski et al. (1992); Roberts et al. (1999); Rosenthal (2008)

clinician that the technique is not being propelled by the clinician's negative feelings (CSAT 2005; Rosenthal 2002). Confrontation is used here in the technical sense, meaning to present to the patient information that brings to his or her awareness something avoided or suppressed or an unrecognized maladaptive pattern of behavior—not the common activity associated with high affective charge, accusation, and invective (Rosenthal 2008). However, confrontational or uncovering techniques may exacerbate symptoms in patients with psychotic disorders, so these may be less appropriate for COD patients with more severe mental disorders (Drake and Sederer 1986). The therapeutic task concerns how to balance using confrontative techniques without being punitive, and using empathic, supportive techniques without being overresponsible (enabling) or fostering regressive, dependent behavior (Rosenthal and Westreich 1999).

Engaging Significant Others and Families

It is often useful to obtain patients' consent to contact significant others. Teaching the family about the nature of the patient's disorders can help stabilize the family around the patient in a way that is more supportive of recovery. Family psychoeducation is a treatment strategy that uses the techniques of empathic engagement, education, continuing support, increased clinical resources during periods of crisis, social network enhancement, and improving problem-solving and communication skills (McFarlane et al. 2003). Individuals with severe mental illness have lower rehospitalization rates and decreased psychotic symptoms when their families attend psychoeducation groups, and especially those with chronic symptoms, have lower rates of relapse to psychosis when the family is engaged in multifamily rather than single-family psychoeducational groups (McFarlane et al. 1995). When family psychoeducation techniques are properly implemented, patients have reduced relapse rates, improved recovery, and families have improved well-being (McFarlane et al. 2003).

Engaging significant others and families also promotes better substance dependence treatment outcomes (DeLeon 1991; Higgins et al. 1994; Sorenson et al. 1985). The techniques of engaging persons other than the patient can range from enlisting families to join only in the initial assessment process (so as to offer supplemental information, another point of view, support for the patient's recovery efforts, or information unavailable to the patient), up to recruiting direct involvement of significant others or families in the ongoing treatment process, either as informal supporters of adherence to program or medication schedules or as part of a network of monitors of recovery behavior that are permitted to communicate with the clinician (Galanter et al. 2002).

More specifically, therapeutic interventions with families and couples have significant positive impact upon recovery from SUD (Stanton and Shadish 1997). In cases where the patient lives or has daily contact with family or a significant other, the techniques of behavioral couples therapy provide elements of increased social support for the patient's efforts to change and the contingency for sobriety, and have positive impact on substance use frequency and consequences (Powers et al. 2008). For example, in those who are being treated with disulfiram, a useful set of techniques is the creation of a contract between the patient and a significant other stating that (1) the significant other will observe the patient taking his daily dose of disulfiram (2) and record that action on a calendar, (3) the patient and spouse will then thank each other for their efforts, and (4) neither will argue or discuss the patient's drinking behavior (O'Farrell and Bayog 1986).

Facilitating Adherence to a Treatment Plan

Since COD treatment requires time, effort and persistence on the part of the patient, understanding the rationale for treatment and having sufficient motivation to engage and continue in treatment is fundamental for positive outcome. Clinical techniques that support patient's understanding about COD are education about mental illness and addictive disease and teaching both about the expected effects of recovery efforts and the negative social,

behavioral, medical and economic consequences of untreated disorders (see patient education, below). Motivation for change is raised and supported by the techniques of motivational interviewing, such as reflective listening, developing perceived discrepancy between actual and ideal behavior, exploring patient's ambivalence about achieving goals, and avoiding argument (Miller and Rollnick 2002). There is significant evidence that motivational interviewing is an effective intervention method for SUD, especially for promoting entry to and engagement in more intensive substance abuse treatment, even when used by nonaddiction specialist providers (Dunn et al. 2001).

Another important adherence technique is for the clinician to assist the patient in formulating useful reminders for remembering treatment-related appointments or tasks, including medication schedules. The clinician directly addresses factors that reduce adherence to prescribed medication, such as denial or chronicity of illness, complex medication dosing schedules, side effects, poor social support, and depression or amotivation (DiMatteo 2004; DiMatteo et al. 2002; Perkins 2002). The clinician should ask frequently about how patients are faring with medications, including beneficial effects, side effects, difficulties with the regimen, and whether they need to see their physicians (CSAT 2005). People with severe mental illness whose families participate in psychoeducation groups have increased medication compliance (McFarlane et al. 1995).

Since medications do not work when they are not taken, and patients with COD tend to difficulty taking medications regularly due to cognitive dysfunction, ambivalence, or a chaotic living environment, using long-acting medications can be framed as an adherence strategy. Techniques that support this approach are those that affect decisional balance through motivational interviewing, supportive skills-building interventions such as psychoeducation, giving advice, modeling adaptive behavior, and supportive esteem-building techniques such as encouragement (Rosenthal 2008). The following therapeutic interaction is an illustration of content and the use of technique.

Patient: "I don't much like taking the medications and I don't remember to take them a lot anyway. I'm usually focused on other things, but I'm getting the symptoms again, and I don't want to lose my good situation." *Expresses ambivalence about taking medications*

Clinician: "You know, we have a way for you to take the medicine in a long-acting form, so you would only need to get an injection after several weeks when you come here for visits. You won't even have to think about it! How does that sound?" *Psychoeducation, adaptive skills*

Patient: "Tell me more."

Clinician: "We know that if your system is exposed to the medication consistently, that greatly improves the benefits over starting and stopping—the long-acting medication is a good way for you to achieve that." *Psychoeducation*,

Patient: "Feels like I'm gonna be controlled if it's in me like that, I don't know…" *Expresses ambivalence*

Clinician: "You have concerns about not being able to stop it once it is in your body, but you also said you have concerns about what the symptoms coming back will do to your recovery" *Reflective listening*

Patient: "I don't want to end up back in the hospital again."

Clinician: "So this may be a way for you to control the decision, and you would be taking steps to further your recovery." *Encouragement, modeling adaptive behavior*

Patient: "I could stop it if I didn't like it and go back to taking pills next time?"

Clinician: "That can be your choice; we'll work together on this." *Reassurance*

Patient: "Ok, I can try it"

Clinician: "So you've decided to try the long-acting medication because your desire to stay healthy has outweighed your

concerns about this form of the medicine. We can look at how you do after the first dose, and discuss whether you wish to continue then. I think you've made a good choice. Now, let's talk more about side effects compared to the oral version." *Summarizing, reflective feedback, empowerment, praise*.

Currently, there are long-acting injectable forms of atypical antipsychotic agents (risperidone, paliperidone palmitate, and olanzapine) as well as long-acting injectable naltrexone for alcohol dependence (Garbutt et al. 2005), and a long acting buprenorphine implant for opioid dependence, likely to be available in the near future (Ling et al. 2010).

Maintaining Engagement in Treatment

People remain in treatment when motivated to do so and supported in their commitment. This can be as a result of several factors: the patient's having a strong affiliation to the providers, other patients, or the program; a decisional balance that is tipped more consciously toward moving forward in recovery and away from the negative effects of untreated drug abuse or mental illness; reduction in symptoms of the co-occurring disorders that diminish mood, energy, motivation, or cognitive function; and/or external forces such as family involvement or court-mandated treatment. Thus, techniques that the clinician uses to further clinical engagement focus upon continually assessing the patient's current motivational state and providing accurate feedback; implementing motivational interviewing (Miller and Rollnick 2002); maintaining attunement to the patient's affective state and relatedness; tracking patient's ability to access healthy rewards; providing interventions matched to the patient's motivational stage; facilitating active use of self-help strategies; engaging significant others or families, which improves treatment retention (Meichenbaum and Turk 1987); and using supportive therapy techniques to deliberately reinforce the therapeutic alliance (Rosenthal 2008). Praising small gains is a supportive technique that clinicians can use to bolster the patient's self-esteem, and provide impetus for continuing treatment engagement (Winston et al. 2004).

Maintaining Long-Term Care

The clinician's recovery perspective and understanding of the recovery process also supports continuity of treatment. The assumptions underlying this is that mental illness and substance use disorders are chronic illnesses, thus the patient may need services indefinitely (CSAT 2005). Given numerous environmental cues and stressors in the community that pull a person toward nonadherence with treatment and relapse, the patient needs support for recovery in the community that is synergistic with formal treatment. One technique that acknowledges this is to assist the patient in developing a support network that espouses healthy behaviors, and provides respect and acceptance, such as a sponsor (ideally with COD and a later recovery stage than the patient), an Alcoholics Anonymous (AA) or other 12-step home group, engagement in a dual recovery mutual self-help group, and new friendships with persons committed to a drug-free and sober lifestyle. Such a network can support the continued development of personal recovery even when they are not receiving an episode of care from a provider or clinical program (CSAT). However, it is important that clinicians recognize that these community support elements are not treatment, and as such, still necessitate the clinical input from a professional to optimize the recovery trajectory.

Facilitating participation in mutual self-help groups is deemed a key technique for working with people with COD (CSAT 2005). Twelve-step facilitation (TSF) is an evidence-based clinical treatment approach designed to acquaint patients with the philosophy of AA and to encourage them to participate in this self-help tool (Nowinski et al. 1992). Research suggests that patients with lower psychiatric severity have better outcomes than those treated with CBT for alcohol dependence (Project Match Research Group 1997). Techniques of TSF that support the recovery of COD patients are as follows: supporting the patients to engage the AA program, not just go to meetings; finding and using meetings

appropriate for the COD patient; handling obstacles and resistance to step work; identifying the damaging interactions of substance use with patterns of thinking, feeling, and both personal and interpersonal behavior (Nowinski et al. 1992).

COD patients may have symptoms such as social anxiety, suspiciousness, behavioral rigidity, or cognitive difficulties that will inhibit the patient's ability to get to and engage in group meetings. In response, and depending upon the circumstances, the clinician should use techniques to acquaint the patient with the group and work through patient's concerns through anticipatory guidance and rehearsal, to engage a significant other in accompanying the patient to the group, to write down specific directions to get to the meeting, and/or to ensure that paranoid ideation has been sufficiently addressed through proper medication, reality testing, psychological support, and motivational practices (CSAT 2005; Rosenthal 2002).

Psychosocial Treatment Strategies

Monitoring the Patient's Clinical Status

Clinicians providing appropriate treatment monitor their patient's progress in treatment and use subjective or objective clinical measures for assessment when appropriate. The main areas of evaluation should be the person's motivational state, sobriety/abstinence, psychiatric symptoms, and his or her perceptions of the specificity and efficacy of the provided treatment (CSAT 2005). These assessments, whether informal or structured, should be performed with enough frequency that, changes could have a positive impact upon recovery without unnecessary delay. Individualized care is necessary as patient characteristics such as genetics, addiction severity, non-substance-related mental disorder severity, motivational stage for both mental and substance use disorders, drug of choice, culture, race, and ethnicity, and living environment will impact what the optimal combination of medications and psychosocial interventions would be for any person. The technique of individualizing care for people with COD is also necessary so as to avoid a mismatch between the patient's motivational stage and the clinician's intervention. The use of techniques appropriate for one recovery stage with a patient who is in an earlier motivational stage will likely cause a patient/clinician mismatch, an incongruence commonly resulting in a highly stressed or ruptured therapeutic alliance, and nonadherence to treatment (Rosenthal and Westreich 1999). Abstinence and sobriety should be monitored both through self-reports (e.g., checklists) and objective measures (toxicology screens, preferably random). All clinicians providing care to those with COD must know techniques to assess a person's mental status for changes in the severity of key psychiatric symptoms, such as depressed mood, suicidality, hopelessness, sleep and appetite, energy, and psychotic symptoms (CSAT 2005). Finally, the patient's feedback to the clinician or program about his or her perceived usefulness of treatment can provide essential information about how the treatment fits the patient's needs, or needs to be improved in quality or even changed. This can take the form of a conversation in the context of a good therapeutic alliance, or might use standardized consumer satisfaction scales to support this endeavor, especially as more service-user specific scales are developed (Greenwood et al. 2010).

Providing Patient Education

Several related educational techniques provide important cognitive restructuring for recovering COD patients in the form of education about mental and substance use disorders, their sequelae and their treatment. These techniques are: psychoeducation, assisting patients in identifying relapse triggers through exploration, and teaching skills concepts to patients. To reduce negative impact, the clinician should understand the patient's capacity to make use of the information in a way that is supportive of ego functioning or enhanced

adaptive skills, and formulate the educational content based in that context. When a person with a SUD learns that he or she has another, chronic mental illness, or vice versa, this knowledge may play a role in the person becoming demoralized, so imparting information, along with supportive techniques such as normalization and encouragement, can assist with the development of coping skills and improved self-efficacy (Rosenthal and Westreich 1999). Typically, psychoeducation about substance abuse focuses on teaching about different classes of drugs and their psychological and physical effects, dangers of chronic abuse including pertinent medical problems, how drugs are used to address negative emotional states, current models of addiction, and benefits of abstinence. Psychoeducation also teaches about symptoms of the mental disorder relevant to the patient, its treatment, and natural history.

Psychoeducation should be framed in the context of a recovery perspective, meaning clinical progress that is the result of active clinician–patient collaboration with concentration on personal goals and engagement in a long-term and developing plan that provides stage-specific interventions and is demonstrated in the clinical outcomes of improved health, better self-care, increased independence, and improved self-esteem (CSAT 2005). The literature suggests that educating patients about their illness reinforces psychosocial rehabilitation of people with severe mental disorders or substance dependence (Goldman and Quinn 1988). In addition, a fact-based and nonjudgmental accounting of the effects of drugs of abuse recruits the intrinsic motivation to change, helping to tip the decisional balance in favor of recovery. When teaching, the clinician must always take the patient's cultural and educational status into account, as patient literacy levels may be lower than the readability level of most treatment-related reading materials (Davis et al. 1993; Greenfield et al. 2005). In addition, as those with COD may have cognitive or memory problems, the therapist takes time to briefly review the main points of the last session (CSAT 2005).

The CBT relapse prevention technique of functional analysis uses teaching, exploration and experiential learning. In this technique, for each substance use episode, the clinician helps the patient to identify his or her thoughts, feelings, and circumstances both before and after the substance use. In addition, the identification of relapse triggers is a CBT technique that helps the patient to identify sources of high risk for drug relapse from among potential high-risk situations, specific environmental cues, thought patterns, and emotions. Both the patient and the clinician learn the patient's reasons for use, such as to cope with interpersonal difficulties, or to experience risk or euphoria not otherwise available.

Part of the recovery process in both substance use and mental disorders is the learning and execution of new, more adaptive behavioral patterns. As such, the clinician teaches about these skills, including relapse prevention skills, which derive from CBT (Kadden et al. 1992; Marlatt and Gordon 1985). Data from numerous clinical trials of CBT suggest a learning curve and practice effects, as patients take time to remember and invoke the skills that have been learned. As such, the efficacy of CBT tends to increase over time for some period after the therapeutic intervention.

Preventing Relapse

A corollary to learning new skills is that in order for them to be useful, a person must put them to use. An important technique in assisting the patient with skills acquisition is skills training through role-playing or rehearsal, where the clinician guides the patient through hypothetical, but typical, situations. A person is thus able to practice: recognizing which circumstances are high-risk, making U-turns away from and avoiding potential high-risk situations, rehearsing drug refusal skills, and steps to minimize the effects of a slip (quit early). These techniques are useful in patients with severe COD, where the patient may have particular deficits in the area of social skills (Roberts et al. 1999).

Specific techniques include exploring both the positive and negative consequences of continued substance use, supporting the patient's

self-monitoring to recognize drug cravings early on and to identify high-risk situations for use, and helping the patient to develop strategies for coping with and avoiding high-risk situations and the desire to use, often identifying with the patient activities that satisfy an emotional need otherwise satisfied by the abused substance. In this manner, dysphoric mood is a frequently reported antecedent state of relapse to substance abuse, so relapse prevention techniques also focus on building adaptive skills for coping with the negative or painful mood states that are more frequent in people with COD (Marlatt and Gordon 1985; Longabaugh et al. 1996). This may be of particular help in patients with schizophrenia, where abuse of substances, and in particular stimulants, may be driven in part by negative symptoms (such as anhedonia or amotivation) that are in fact ameliorated by the actions of those substances. In addition, techniques that help patients address negative thoughts are helpful, as they often accompany or trigger dysphoric states, and serve as high-risk situations. The skills clinicians can teach patients for managing negative thoughts include thought stopping, positive self-talk, and substituting positive thoughts or feelings. CBT may hold particular promise in reduction in the severity of relapses when they occur, enhanced durability of effects, and patient–treatment matching, particularly for patients at higher levels of impairment along such dimensions as psychopathology or dependence severity (Kadden et al. 1992).

Medical Strategies

Managing Intoxication and Withdrawal States

Patients who are acutely intoxicated need a safe environment within which to sober up, an environment that also provides adequate medical monitoring for consequences of the substances used or for acute withdrawal symptoms. The clinician needs to be able to understand what substances the patient has taken, in what amounts, and over what time. Depending upon the type and dose of substance the person is intoxicated with, he or she will need to be variously provided with: a low level of stimulation (a low light, low sound environment), reassurance, safety precautions, reality testing, and medical management (e.g., minimizing drug effects through use of antagonists, gastric lavage, changing urinary pH, sedation).

Many patients who meet DSM-IV-TR dependence criteria will not develop physical symptoms of withdrawal after cessation of substance use (APA 2000). The substances that typically produce physical withdrawal symptoms in those with substance dependence are in the sedative-hypnotic group (e.g., alcohol, benzodiazepines, barbiturates) or the opioid group (e.g., prescription narcotics and heroin). Other substance groups (stimulants, cannabis) may produce withdrawal symptoms, but they produce less in physiologic symptoms (e.g., blood pressure and heart rate), and more in mental and mood symptoms such as agitation, dysphoria, anxiety, and irritability. Medical personnel who work with COD patients must know the techniques of supporting medical withdrawal from each class of substances, and must recognize that COD may intensify at least the subjective symptoms of withdrawal.

Using Medication

Medications to treat traditional psychiatric illnesses are well employed by psychiatrists, yet unfortunately for patients, the same is not true of the use of medications for the treatment of SUD, in spite of the fact that there are many evidence-based medications for SUD. These medications work best in combination with psychosocial approaches and are described in detail in Chap. 23. The text box below describes some key practical points that the community psychiatrist can use in employing pharmacology in COD.

1. Abstinence should not be a requirement to begin pharmacotherapy for a co-occurring Axis I disorder, unless there is a specific contraindication to that medicine for a particular intoxication or withdrawal state. For example, one generally should not use medications during sedative-hypnotic withdrawal that lower the seizure threshold, such as antipsychotics or antidepressants.
2. Treat all treatable non-substance-related mental disorders, avoiding medications with a high abuse liability, if possible. The first choice for treating chronic anxiety should not be a short-acting benzodiazepine. Try other, less risky strategies first.
3. Unless contraindicated, evidence-based medications for SUD should be used to treat SUD in patients with COD. Don't avoid treating SUD with pharmacotherapy in patients with mental disorders, as they may have an appropriate, even synergistic response (Petrakis et al. 2004).
4. Be careful in choosing and dosing medication, but don't undertreat. Cover as much ground with the fewest number of medications, and, minimize the schedule for dosing to once daily, if effective. Consider long-acting medication preparations for patients with high disorganization and poor social support, unstable living environments, or other chaotic elements lowering the likelihood of adherence to an oral regimen.
5. "Start low, go slow." Patients with co-occurring disorders may have increased initial sensitivity to medications, and have difficulty tolerating side effects, but they may ultimately need a higher dose than patients without SUD (Kranzler et al. 1994).
6. It is best to use medications with a high safety index and low capacity for inducing delirium or seizures, as those with COD may have a lower threshold for CNS side effects (Olivera et al. 1990).
7. Syndromes are less hazardous to treat than individual symptoms (e.g., insomnia, anxiety, dysphoria). When the patient communicates multiple complaints that may be independent of Axis I disorders, it is easier for the clinician to become uncertain about medication response.

Adapted from Rosenthal and Westreich (1999)

Reducing the Morbidity of Substance Use Disorders

New patients should have a medical screening examination in order to assess general health, and to assess the medical impact of substance use. This is because, in addition to substance-induced damage to different organ systems in the body, both patients with SUD and those with severe mental disorders are less likely to engage in adequate self-care, including periodic medical examination (CSAT 2005). Because of impulsivity, and varying routes of drug administration, people with COD are at high risk for sexually transmitted diseases, and other infectious diseases such as HIV and hepatitis C, in addition to the medical disorders that are direct effects of acute and chronic SUD. People coming to treatment are often demoralized and adopt a fatalistic posture due to the negative impact of substance abuse and mental illness, and the difficulties coping with both disorders (Winston et al. 2004). As such, treating clinicians can be supportive and use motivational interviewing techniques to increase the possibility that patients will follow-up with necessary medical care.

Implementing Techniques

Techniques to Convey Information to Patients

Supportive psychotherapy should always be the foundation of provider-to-patient communication, since it is based on the factors common to

all psychotherapies, and there are relatively few circumstances where it is not indicated (Frank 1975; Pinsker 1996). This is because the techniques of supportive psychotherapy are direct measures specifically geared to maintain, restore, or improve self-esteem, adaptive skills, and psychological functioning (Rosenthal 2008). Thus, even difficult information can be presented to a patient in a respectful, direct, supportive and alliance-building fashion.

Several component techniques of supportive therapy are specifically useful in engaging with people and promoting their self-efficacy. First, the therapist's empathic attitude of acceptance, respect, and interest serves as a basis in which the patient can feel welcomed and supported. Next, specific supportive techniques such as teaching, encouragement, reassurance, exhortation, modeling, and anticipatory guidance can be used to inform. *Exhortation* is the use of easily understood and remembered common phrases or slogans in order to convey important concepts to persons who may be cognitively impaired or frequently distracted by cravings or impulses (e.g., "Use HALT to remember your negative mood triggers—hungry, angry, lonely or tired!"). *Modeling* is where the provider serves as an exemplar of the adaptive behavior desired in the patient. *Anticipatory guidance* is the technique whereby the provider assists the patient in anticipating obstacles to a proposed course of action and rehearsing his or her behavior so as to deal successfully with those obstacles (Winston et al. 2004, Chap. 3).

People often have negative self-evaluations about their own maladaptive behavior due to COD, typically worse with more severe disorders. Individuals coming from an environment high in perceived stigma are more likely to develop self-stigma, with attendant negative impact on role function, self-esteem, morale, social and treatment engagement, and symptom severity (Brohan et al. 2011; Yanos et al. 2008). Normalization is a supportive technique protective of the patient's self-esteem by reframing what the patient thinks of his/her own behavior or experience as not unusual and more generally acceptable; however, care must be taken in that it may at times inhibit change in that it can conflict with the intent of the motivational interviewing technique of developing discrepancy (Rosenthal 2008). Techniques that support patients' experiences of self-efficacy should be implemented because empowerment and expanded areas of social contact are associated with lowered self-stigma (Brohan et al. 2010, 2011). These can be the supportive techniques of data-based praise (finding and declaring something that the patient will experience as praiseworthy), reassurance and encouragement (Rosenthal 2008), the motivational interviewing techniques of engaging demonstration of patient's strengths and capacity to change through eliciting self-motivational statements (Miller and Rollnick 2002), or the CBT technique of cognitive restructuring, where clinician and patient collect evidence to examine and challenge the validity of self-stigmatizing beliefs formed as cognitive distortions or dysfunctional attitudes (Yanos et al. 2008).

Within a supportive context, the techniques of motivational interviewing (CSAT 1999; Miller and Rollnick 2002) should be implemented for people with COD to elicit change in cognitions and behaviors. In addition to core supportive techniques such as holding an empathic, nonjudgmental stance, and avoiding argument, motivational interviewing also includes reflective listening and eliciting motivational statements, developing discrepancy (examining both sides of a patient's ambivalence), monitoring patient readiness for change in order to reduce resistance, and rolling with resistance (Miller and Rollnick 2002). Thus, while building a therapeutic alliance, the provider imparts information that is likely to motivate the patient toward healthier decisional process.

Increasing the Validity and Impact of Feedback Provided to Patients

In order to affect the decisional balance between a patient's tendency to continue to use substances and his or her countertendency to stop, accurate information must be supplied in a nonthreatening and nondemeaning fashion, which will add to the patient's knowledge base and beliefs about

the negative consequences of substance use. Therefore, the motivational interviewing technique of providing feedback is useful, as valid information assists the patient in developing perceived discrepancy between present behavior and personal values or goals (Miller and Rollnick 2002). The highest quality information tends to take the form of concrete personal measures generated by objective methods, results of which the patient can then read and discuss with the provider. These typically take the form of checklists, urine toxicity screens, and laboratory reports. For example, even with persons with severe COD, feedback consisting of graphical representations of participant responses compared to normative data (for level of nicotine dependence), as compared with nonsmokers (for expired breath carbon monoxide), and without comparisons (for medical consequences of smoking, money spent on cigarettes, importance of quitting smoking, and confidence in the ability to quit) has a positive impact upon engagement in smoking cessation treatment (Steinberg et al. 2004).

In addition, more general normative data about alcohol and substance abuse from national sources such as the federal Substance Abuse and Mental Health Services Administration (SAMHSA) can be used for more general feedback (SAMHSA.gov). For example, going on-line to the SAMHSA Web site, where five standard drinks at a sitting for men (four for women) is defined as an episode of "heavy drinking," can be a useful form of feedback. Conversely, hearsay and common myths tend not to have the same motivational impact, as they are more easily questioned and refuted. An additional source of useful feedback can be presented in the form of other patients' responses and stories related to their use of substances, or nonadherence to medication. For example, a particular strength of mutual-help peer groups is that members get to hear others share the negative consequences of drinking and drug use in the context of a supportive and like-minded group. Similarly, in a program-based recovery group, senior members, with clinical oversight, can offer new members information based in their own experience, about the whys and wherefores of early recovery (Rosenthal 2002).

Using Techniques to Help Address the Social Consequences of Co-occurring Illnesses

COD has direct effects on personal and interpersonal functioning that are accepted symptoms and sequelae of the specific disorders, and that are the obvious foci for evaluating the efficacy of our treatments. However, there are also negative social consequences of co-occurring disorders, which are varied, and range from individual internal effects of stigma upon functioning such as lowered self-esteem, lower motivation and disempowerment, to interpersonal and systemic impairments such as disenfranchisement from families, the workforce and systems of care. These are the less obvious areas for clinical technique, yet they are important for the recovery of the person with COD, so it is important that clinicians evaluate the people they treat in ecological terms, not just how they appear with respect to symptoms and function in the clinic setting. There are techniques that support and empower people in the face of stigma, those that help them better negotiate organizations, rules, and bureaucratic responses to their needs, and those that address disenfranchisement. Techniques that improve the patient's safety are also important. For example, homelessness may be a mediator of risk for relapse to substance abuse and exacerbation of mental illness (Boisvert et al. 2008; Kertesz et al. 2005). Intensive or assertive case managers can use interpersonal, teaching, and management skills to defuse conflict between a client and a landlord who is threatening eviction, thus potentially reducing the risk of relapse.

Making an Appropriate and Effective Referral

In order to make "good referrals that stick" providers must implement techniques to properly assess the patient, techniques with which to network with other agencies, and techniques that create alliances with other providers and provider groups.

A useful technique in creating a network of care for COD patients is the crafting and execution of a structured reciprocal agreement by one of the treatment providers, which binds together the care of an identified patient between separate provider systems. Reciprocal agreements can be powerful networking tools for supporting interagency cooperation and flow of patients across treatment settings. These agreements create a pathway for patients to move between levels of care without the usual stress about placement out of one's domain. For example, a community service provider with a patient with COD who frequently expresses suicidal ideas can enter into an agreement that the hospital-based program will assess the patient for hospitalization on an as-needed basis, provided the community-based program agrees to take the patient back into treatment post discharge. This may give the community provider greater capacity to more effectively work with the patient. That is, paradoxically, understanding that the hospital will freely accept the patient in crisis reduces pressure to actually use the hospital. This anxiety-reducing supportive intervention implemented at an institutional scale fosters the construction of a working alliance between the provider systems over time.

Summary and Future Directions

Although infrequently studied, the individual treatment techniques underlying engagement, psychosocial and medical treatment strategies are the basic and necessary clinical armamentarium for clinicians who wish to treat patients with COD. Many of the techniques described are generalizable to engagement strategies with non-COD clinical populations, such as forming and maintaining a robust therapeutic alliance, engaging and educating significant others, and maintaining treatment adherence and engagement. Similarly, techniques supporting strategies that focus on the transfer of clinical information are also more broadly generalizable: delivering motivating clinical feedback and education to patients, monitoring the patient's clinical status, and using the patient's own experience to inform the prevention of relapse and to empower. There are probably many effective techniques in use that will not gain wide dissemination unless packaged and tested to generate a proper evidence base. Future research should examine practice-based as well as hypothesis-driven designs to discover what clinical advances have been generated in the treatment setting.

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Part V

Tried and True: Major Evidence Based Practices

23 Evidence-Based Practices for Co-occurring Chemical Dependency and Mental Illness

Christine Yuodelis-Flores, Richard K. Ries, and W. Murray Bennett

Introduction

Development of an integrated co-occurring disorder (COD) program in the community mental health center is essential for comprehensive care. Research shows that about half to two thirds of patients served by community mental health centers have ongoing or past substance use issues that profoundly impact diagnosis, treatment planning, and outcomes. Addiction is a chronic relapsing and remitting disorder that severely impacts the course, treatment and prognosis of mental illnesses and presents complex challenges for providers. Conversely, mental illness also impacts the course and treatment of the substance use disorder (SUD). Providers are in need of adequate training and supervision to work with this population and careful treatment planning with coordinated interventions is essential for success. Without the appropriate support, feelings of helplessness, therapeutic nihilism and burn-out will plague the mental health center staff. Clinicians unprepared to treat addictive disorders may avoid treating the COD patient, referring the individual to another treatment program, or alternatively make treatment demands that the individual cannot achieve. Better outcomes are possible and rewarding for both the participants and the providers by organizing effective interventions through practical evidence-based clinical approaches.

Historically, patients with both mental health and addictive disorders would receive treatment for one disorder only after the other disorder was treated and stabilized or they were provided with mental health treatment in one setting and addiction treatment in another. In severe COD it is nearly impossible to prioritize which condition needs to be treated first or to retain a patient long enough in treatment to resolve one condition while not addressing the other. COD patients have been shown to do poorly in traditional addiction treatment without some emphasis on their comorbid psychiatric conditions. Thus, there is a concerted effort nationally to transition toward an evidenced-based model of integrated treatment, in which providers knowledgeable about both conditions treat mental illness and SUD concurrently in the same program (Drake et al. 2001). This chapter discusses the prognosis and complications of CODs, provides an overview of integrated treatment, and delineates the role of evidence-based medical and psychosocial treatment, treatment teams, group therapies, and ancillary services such as self-help groups, vocational and housing support commonly used in co-occurring treatment programs.

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Scope of Co-occurring Disorders in the Community

Epidemiological studies show that CODs are very common in the general population. Results from the Epidemiological Catchment Area (ECA) Survey (Regier et al. 1990) showed greater than 60% lifetime prevalence rate for SUD in those diagnosed with bipolar disorder and in those with schizophrenia, nearly half have a lifetime diagnosis of an alcohol or drug use disorder. The ECA survey also found that one third of individuals with a mood disorder had a lifetime history of a comorbid SUD. A more recent study, the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) (Grant et al. 2004) reported that of those with drug use disorders (DUD) who sought treatment over the past 12 months, 60% had an accompanying mood disorder and 43% had an anxiety disorder. Forty-one percent of those with alcohol use disorders (AUD) presenting for treatment had a mood disorder and 33% had an anxiety disorder. Polysubstance use is more common than not in those with DUD.

There is a significant association of SUD with Axis II disorders. Among those in the NESARC study with current AUD, 29% had a personality disorder diagnosis and among those with DUD, 48% had that diagnosis. Antisocial personality disorder holds the distinction of being the most comorbid psychiatric illness in patients with addictive disorders, followed by borderline personality disorder. In treatment populations, the prevalence of personality disorders is higher than in household surveys and are estimated at 44% of patients with AUD and almost 80% of opiate abusers (Verheul et al. 1995).

Prognosis and Complications of Comorbid Disorders

Addiction alone predicts an increase in completed suicides for the nonpsychiatrically ill. Murphy and Wetzel (1990) estimated the risk for suicide in alcoholics was between 60 and 120 times that of the general population. For other drugs of abuse, association with suicide is even more compelling. A meta-analysis of world-wide suicide studies (Harris and Barraclough 1997) reported that suicide risk is 14 times that expected for those with opioid dependence, 17-fold increased for mixed drug abuse, 20-fold increased for prescription drug abuse and 44-fold increased for combined prescription and illicit drug abuse. Although men have a higher rate of completed suicide, the association of suicide with SUD is markedly stronger for women (Wilcox et al. 2004).

Depression has a significant adverse effect on the course of substance dependence, predicting poor treatment response, increased risk of suicide and higher rates of relapse (Murphy and Wetzel 1990; Greenfield et al. 1998). One year of sobriety from alcohol is associated with a threefold reduction in risk of depression (Agosti and Levin 2006). However, the rate of current depressive disorders in alcoholics sober for greater than a year is still four times that of the general population (Hasin and Grant 2002). Subjects with co-occurring major depressive disorder and AUD report more previous depressive episodes, suicide attempts and recent adverse life events (Sher et al. 2008). Substance-induced depressive disorders also increase the risk of suicidal behavior. Ries and colleagues studied acutely suicidal psychiatric inpatients with substance-induced psychiatric disorders and found that this subgroup had higher severity of suicidal ideation but improved more quickly than other patients and tended to have shorter lengths of stay (Ries et al. 2008b, 2009).

It can be very difficult to differentiate between substance-induced and independent depressive disorders and the diagnosis may change if the patient is followed over time. Nunes et al. (2006) studied depressive disorders in patients with alcoholism admitted to an inpatient psychiatric unit and found that about half of patients had substance-induced depression; however, after following them for a year period, one third of those with substance-induced depression were reclassified as having independent depression.

More than a third of panic disorder patients have a lifetime history of SUD (Regier et al. 1990). Among alcoholics, preexisting anxiety

disorders (in particular social phobia and panic disorder) predict a significant increase in relapse rates (Driessen et al. 2001). Patients with post-traumatic stress disorder (PTSD) have increased risk for DUD and AUD which is two to four times greater than non-PTSD patients (Kessler et al. 1995) and rates of PTSD among female opiate and cocaine dependent patients were increased tenfold using ECA data (Cottler et al. 1992). Addiction treatment outcomes in these women can be highly dependent on the availability of supportive psychosocial and psychiatric care (Najavits et al. 1997).

Substance abuse worsens the course of illness and treatment outcome in bipolar disorder and is associated with increased violence against self and others. Bipolar patients with addictive disorders are less adherent to treatment (Strakowski et al. 1998), have more and more prolonged affective episodes (Tohen et al. 2003), and lower overall quality of life (Weiss et al. 2005) in comparison to non-substance-using bipolar patients. Around 30% of individuals with bipolar disorder will attempt suicide and the presence of SUD doubles the risk for suicide attempts (Comtois et al. 2004). Although literature review demonstrates that in general bipolar type II patients carry greater lifetime suicide risk (Rihmer and Kiss 2002), studies considering the co-occurrence of bipolar disorder and AUD have found type I patients are at double the suicide risk of bipolar type II (Potash et al. 2000).

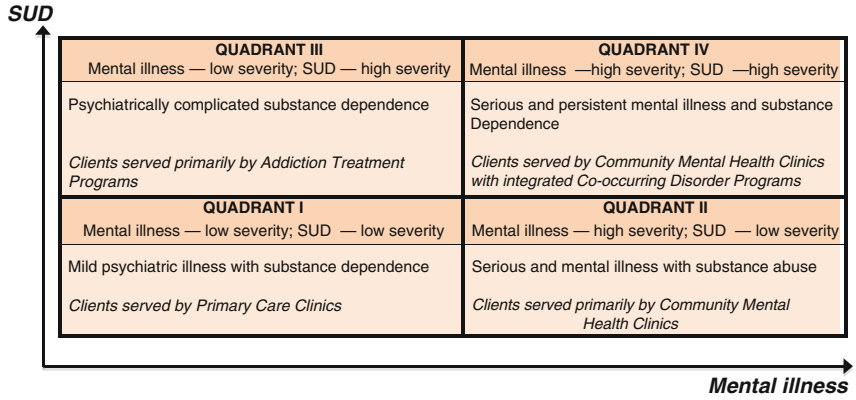
Comorbid addiction and schizophrenia increases likelihood of homelessness, legal problems, violence and victimization, treatment non-compliance, multiple medical problems, frequent emergency visits, frequent hospitalizations, and suicidal behavior (Bartels et al. 1993; Mueser et al. 1992; Ziedonis et al. 2004). Comorbidity predicts poor prognosis, vulnerability to social dysfunction, suicide attempts, and more problems with housing and finances (Drake et al. 1990). Denial and minimization are often observed in patients with comorbid schizophrenia and addiction indicating that traditional recovery principles may not be accepted.

Stimulant-induced psychotic disorder is very common during intoxication and withdrawal. In chronic methamphetamine use, the presence and duration of psychotic symptoms increases with severity and length of dependence and is particularly associated with long-term intravenous use. A small percentage of chronic intravenous methamphetamine dependent patients can present with long-term psychotic symptoms that appear almost identical to paranoid schizophrenia as studied in the Japanese population where an "epidemic" of intravenous methamphetamine use has occurred over a long period of time (Ujike and Sato 2004; Akiyama 2006). In the US population, the abuse of smokable methamphetamine also known as "crank," "ice," or "crystal" is more common than intravenous methamphetamine use. Chronic use of this drug is associated with longer duration of psychotic symptoms (up to several months) as compared to smokers of crack cocaine.

Axis II disorders also present significant challenges to addiction treatment and these patients are at greater risk of relapse, are more likely to drop out of treatment, and are associated with more severe treatment problems (Westermeyer and Thuras 2005). It has been reported that 75% of those with borderline personality disorder attempt suicide and 10% eventually complete suicide (Black et al. 2004). The co-occurrence of SUD increases the risk of suicide attempts. One study (Suominen et al. 2000) found that 70% of suicide attempters with personality disorders had SUD and 50% had AUD. Integrated treatments for those with co-occurring addiction and personality disorders show the most promise using dialectical behavioral therapy or dual focus schema therapy adapted for addiction treatment (Linehan et al. 1999; Ball et al. 2005).

Screening and Assessment of Substance Use Disorders in Community Mental Health

All people presenting for mental health treatment should be screened for past and present SUD and related problems. Individuals should also be screened for acute safety risk related to intoxication, potential for overdose or withdrawal and suicidality. Positive screening needs to be followed up with a more detailed assessment. A variety of



Source: National Advisory Council, Substance Abuse and Mental Health Services Administration. (1997). Improving services for individuals at risk of, or with, co-occurring substance-related and mental health disorders. Rockville, MD

Fig. 23.1 Four quadrant model

screening tests are in use for detection of SUD. One clinically useful screening tool is the Global Appraisal of Individual Needs-Short Screener (GAIN-SS) (Dennis et al. 2006), a very brief instrument designed to identify individuals who are likely to have a mental health and/or SUD and who should be referred for further assessment or treatment. It is used to place individuals into one of the four quadrants of care to determine the level of integrated treatment (see Fig. 23.1).

Laboratory screening including a urine toxicology screen, complete blood count and differential and hepatic function tests should also be done on anyone with a past or present SUD. If an individual presenting with mental illness screens positive for a SUD, the next step will be assessment of the severity of the SUD and its temporal relationship to the mental illness, which is important for diagnosis and treatment planning (see Box 1).

Box 1 Assessment of SUD and Relationship to Mental Illness

1. Document timeline: History of substance use, treatment, relapse, and recovery and onset of SUD in relation to onset of mental illness.
2. Assessment of negative consequences of SUD (psychiatric, social, and medical).
3. Determination of mental health and addiction symptom severity and placement in one of the four quadrants of care (GAIN-SS).
4. Assessment of motivation (stage of change).
5. Develop treatment plan: detoxification, treatment setting, individual and group therapy, case management, pharmacological management.

Patients at significant risk for suicide will need management of their detoxification in an inpatient psychiatric facility where clinical safety can be intensively monitored. Indicators of such risk include active suicidal ideation, severe mood symptoms, and a history of past suicide attempts. The American Association of Addiction Medicine (ASAM) has designed patient placement criteria (Mee-Lee et al. 2001) to guide clinicians in determining a patient's level of need and matching them to an appropriate setting. The placement criteria distinguish between five separate levels of care, and patients move between levels as their addictive disorder stabilizes. Similarly, the American Association of Community Psychiatrists (AACP) integrates comorbid disorders, such as chemical misuse, into its validated Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) (American Association of Community Psychiatrists 2011).

Principles of Integrated Treatment

The goal of integrated treatment is to provide comprehensive, continuous care emphasizing recovery principles and focusing on individualized treatment plans. It includes a multidisciplinary team approach with providers trained in both addiction and mental health. Integrated programs also include a variety of evidence-based psychosocial treatments, pharmacological treatment including both psychiatric and addiction medication, and comprehensive support services such as vocational and housing assistance. Principles for the care and treatment of persons with COD and principles of a comprehensive and integrated system of care are summarized in Box 2 and are available as a publication online at the AACP

Box 2 Principles of Integrated Treatment

1. *Common treatment philosophy*. Both addiction and mental illness have a similar chronic relapse/recovery course which necessitates client and family participation, consumer support, education about illness and adherence, relapse prevention skill training, continuity of care and tailored, flexible treatment planning with motivational approaches to combat shame, denial, and demoralization.
2. *Motivational approach*. Many patients with severe mental illness do not recognize that substance abuse is a problem and are not motivated to maintain abstinence. Thus, it is important to foster a client-focused therapeutic alliance, utilize harm-reduction techniques, and incorporate motivational interventions in a stage-wise manner that corresponds to a patient's stage of recovery.
3. *Coordinated treatment interventions at each phase of care*. Treatment interventions for persons with COD should be matched according to the diagnosis of each disorder, the phase of treatment and recovery for each disorder, and acuity, severity, disability, and motivation for treatment of each disorder at any point in time.
4. *Individualized treatment*. Treatment should be tailored to individual need and strive to provide each consumer with a balance of appropriate case management, care, and empathic detachment. Integrated programs include components of assertive outreach, case management, group interventions, individual counseling, and family interventions.
5. *Continuity*. Continuous integrated treatment relationships should be maintained over time, through multiple episodes of acute and subacute treatment, and which are independent of any particular setting or locus of care.
6. *Optimism and recovery*. People with COD become demoralized with successive failures to achieve recovery and this attitude is sometimes perpetuated by their treatment team. Pessimistic attitudes about people with COD represent a major barrier to successful system change and to effective treatment interventions. Every person with COD is considered to have potential to achieve dual recovery.
7. *Acceptance and accessibility*. In an accessible system for persons with COD, crisis services are available to provide welcoming, empathetic, culturally sensitive, and competent assessment and intervention for psychiatric and addictive disorders without barriers or waiting lists. They do not require such patients to self-define as either "psychiatric" or "substance abuse" or "dual" in order to be accepted for evaluation and treatment.

Adapted from American Association of Community Psychiatrists. (2000). *Principles for the care and treatment of persons with co-occurring psychiatric and substance disorders.* Retrieved February 26, 2000, from http://www.communitypsychiatry.org/.

Web site: http://www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/dualdx.aspx.

Critical Components of an Integrated Co-occurring Disorder Program

1. *Treatment team.* The multidisciplinary case management team is an important component of an integrated treatment approach. The team provides mental health and addiction interventions by the case manager, the addiction specialist, the psychiatric nurse, and the prescriber. Additional team members may include a psychologist and pharmacist as well as vocational, housing, and peer specialists. Cross training of the treatment team through continuing education on CODs is important for basic COD treatment capability. The role of the community psychiatrist on this team is to assess the patient's mental illness and degree of addiction and their relationship to each other, stabilize the patient with psychiatric medications, and appropriately integrate addiction medication when necessary. The psychiatrist's role is to also educate and ensure that the members understand the impact of mental illness and SUD on each other so that the interventions can be coordinated to provide a person-centered treatment plan. For example, a case manager or addiction specialist may not be able to identify or assess the limited cognitive abilities or impairment of insight in some patients with severe mental illness (SMI) and thus be unable to modify interventions to accommodate this. A psychiatrist or psychologist can assess this and identify modifications necessary to help the person succeed in treatment.
2. *Phased treatment.* Coordinated treatment interventions should be based on readiness for treatment and level of engagement. Phases of treatment for psychiatric and substance disorder often differ, and persons may move in either direction from one phase of treatment to another (see Box 3).

Box 3 Integrated Treatment Phases Based on Readiness for Treatment and Level of Engagement

Phase 1. Acute stabilization—Short-term focused intervention to stabilize the acute manifestation of the disorder.

Phase 2. Engagement/motivational enhancement—Interventions designed to establish a primary clinical relationship and to facilitate the person's ability and motivation to initiate and maintain participation in a program of stabilizing treatment.

Phase 3. Active treatment/maintenance—Interventions of any type designed to stabilize the symptoms of the disorder, prevent relapse, and help persons to maintain a stable baseline and optimal level of functioning.

Phase 4. Rehabilitation and recovery—Interventions designed to help develop new skills, reacquire old skills, and achieve personal growth and serenity, once prolonged stabilization has been consistently established.

Adapted from American Association of Community Psychiatrists. (2000). *Principles for the care and treatment of persons with co-occurring psychiatric and substance disorders.* Retrieved February 26, 2000, from http://www.communitypsychiatry.org/.

3. *Comprehensive services.* Supportive services would include 24 h crisis care and inpatient referral; residential, vocational and parenting supports, money management and financial counseling services, medication management assistance, physical health assessment and referral, and peer support networking, such as 12-step groups.

Evidence-Based Psychosocial Treatments for Co-occurring Addiction and Mental Illness

Evidence-based treatments available for treatment of SUD include motivational enhancement therapy (MET) (Minkoff 1989), relapse prevention therapy (RPT) (Marlatt and Gordon 1985),

twelve-step facilitation (TSF) (Ries et al. 2008a), and contingency management (CM) therapy (Rawson et al. 2005). Intensive case-management is also often used in COD programs for those patients with SMI. All these interventions are modified for those with SMI who may have challenges with reality testing, motivation and self-efficacy, interpersonal skills, and cognitive deficits. The COD treatment approach is more flexible than traditional addiction treatments and emphasizes decreased confrontation, greater sensitivity to individual differences, and more direct affirmation for achievements.

Motivational Enhancement Therapy

MET is a brief, patient-centered directive therapy focusing on interventions designed to enhance motivation for change and facilitate transition from one stage of change to the next. As described by Prochaska et al. (1992), change is a process that proceeds through five identifiable stages: precontemplation, contemplation, preparation, action, and maintenance. It is important to assess the COD patient to determine which stage of change s/he is at so that the clinician can match specific interventions to facilitate forward movement to the next stage. Interventions for the precontemplation stage include developing a therapeutic alliance by being nonjudgmental and expressing empathy; harm-reduction by raising awareness of risky behaviors; and education about the role of substance use in sustaining or worsening psychiatric symptoms. At this stage, the client is frequently not aware of the link between substance use and psychiatric symptoms. The clinician facilitates greater awareness by exploring substance use patterns around times of stress or illness exacerbation. In the contemplation stage, ambivalence about change is present and the clinician's role is to facilitate exploring pros and cons of behavior change via a decisional balance analysis. Other motivational techniques include exploring triggers or cues that led to prior relapses, healthier alternatives to substance use and helping the patient problem-solve around barriers to success. Demoralization is a common problem which MET addresses by utilizing empathy, affirmation of individual strengths, offering alternative perspectives, and pointing out discrepancies in self-defeating statements while maintaining that successful change is always possible.

Carl is middle aged with bipolar disorder and a long history of heroin, cocaine, and cannabis dependence who attained stable remission from his SUD by means of buprenorphine treatment and his COD mental health program. He was initially served by a parallel addiction program for buprenorphine but soon dropped out due to frequent relapses on cocaine, combined with a feeling that his addiction counselor disapproved of his relapses and doubted his sincerity and commitment to recovery. His buprenorphine treatment was consequently taken over by his COD program and he quickly regained sobriety, reengaged with his co-occurring group and voluntarily tapered off the buprenorphine over the next 3 months. During the following year, he attended a COD group with relapse prevention and supportive group therapy modified for patients with severe mental illness. He also attended a dual recovery twelve step group, had a mental health case manager experienced with co-occurring disorders, and his psychiatrist maintained him on his psychotropic medications. He attained 6 months of sobriety from all substances but then relapsed for a week-long period on cocaine. Because of a strong therapeutic alliance with his case manager, he was able to be honest about his use, analyze the triggers leading to his relapse, reaffirm his commitment to recovery and continue his COD treatment again, achieving a long period of sobriety. He revealed to his psychiatrist that a strong motivating factor was when his case manager told him that she still viewed him as a "clean and sober" person despite his recent lapse. He felt honored by this simple affirmation indicating that she had faith that he would be able to resume his recovery based on his long sober period before the relapse. By "normalizing" the relapse, reassuring Carl that his treatment team did not view his relapse as a permanent setback nor as evidence that he was failing and supportively encouraging him to continue in treatment and 12-step groups, he was able to reachieve a long period of sobriety. Over the course of the next 3 years, Carl would relapse on cocaine for short 1–2 day periods about every 6–9 months, but he never relapsed on heroin or cannabis, and he continued to attend his recovery groups, take his medications, and attend 12-step meetings.

Relapse Prevention Therapy

RPT is a form of cognitive behavioral therapy (CBT) which focuses on the relapse prevention model of Marlatt and Gordon (1985) and addresses maladaptive thoughts and behaviors regarding the abused substance. The goal is abstinence through functional analysis of high-risk situations or "triggers" for relapse followed by development of coping strategies through skills training. RPT facilitates the following: understanding patterns of drug use; recognizing high-risk situations; coping with cravings; enhancing social supports; developing drug-refusal and problem-solving skills; developing emergency plans and making better decisions (Ouimette et al. 1997). RPT for COD clients educates about the impact of drugs and alcohol on SMI and clients are taught to manage both of these chronic illnesses to attain stable remission. RPT groups should be modified for those with SMI, emphasizing behavioral techniques over cognitive therapy, problem-solving skills and incorporating social skills training. Group members provide empathy and sober peer support, as well as enhance individual insight.

Twelve Step Facilitation Therapy

TSF goals are to encourage illness acceptance, abstinence, spirituality and attendance at Alcoholics Anonymous (AA) and other 12-step meetings. There is an instruction manual (Nowinski et al. 1995) for this evidence-based therapy and clinicians can incorporate elements of TSF into medication management visits, case-management, group therapy or individual psychotherapy (Ries et al. 2008a). TSF is modified for clients with co-occurring SMI by encouraging participation in Dual Recovery Anonymous (DRA) meetings for those who may not be able to tolerate traditional AA meetings or 12-step therapy. DRA meetings are smaller and more private, less confrontational, and they emphasize peer support and insight enhancement by addressing both recovery from SMI as well as addiction. DRA groups are often led by peer support aides at hospitals and community mental health clinics.

Contingency Management Therapy

CM is a behavioral treatment based on the systematic application of positive reinforcement to reward achievement of goals in treatment. In the case of addiction treatment, it involves the patient receiving draws for prizes or vouchers exchangeable for rewards contingent upon some desired result such attendance at meetings or negative urine toxicology screens. CM has been studied and shows evidence of efficacy across drug types and also with COD patients in outpatient mental health programs and even with homeless clients (Bellack et al. 2006; Ries et al. 2004; Tracy et al. 2007).

Evidence-Based Psychopharmacological Treatment of COD

Pharmacotherapy can be both safe and effective in these patients when used in conjunction with psychosocial treatment although it is best to minimize medications that may be reinforcing, have abuse potential or can lead to dependence. Avoiding medications that can have lethal interactions with the substance of abuse in actively using patients is also clearly important. For example, tricyclic antidepressants and benzodiazepines increase the risk of overdose with alcohol and other CNS depressants as well as increase risk of overdose with abused opioids or opioid-substitution treatment with buprenorphine and methadone. Risk of misuse can be limited if patients with comorbid anxiety can be adequately controlled with scheduled prophylactic medications such as serotonergic antidepressants, anticonvulsants, alpha or beta blockers, or buspirone, rather than reinforcing "prn" medications. Patients who do need "prn" anxiolytics may do better with uncontrolled substances such as hydroxyzine or low-dose atypical antipsychotics.

Pharmacological management of psychiatric illness in patients with addictive disorders is often complicated by difficulty of diagnosis: is it substance-induced or a true COD? In the absence of significant suicidality or clearly disabling symptoms, clinicians may withhold pharmacological

treatment of mood or anxiety symptoms until the diagnosis is clearer. Alcohol-induced depression should remit after 2–3 weeks of abstinence and cocaine-induced depression is even shorter. However, untreated depression in the setting of alcohol (Greenfield et al. 1998), cocaine (McKay et al. 2002), and opioid dependencies (Kosten et al. 1986) have been shown to lead to treatment-resistant substance dependence.

Significant psychiatric symptoms prior to development of an addictive disorder or psychiatric symptoms atypical for a psychiatric disorder secondary to the patients' abused substance (i.e., psychosis or mania in the setting of opioid dependence) are suggestive of a separate psychiatric condition rather than one that is substance-induced. Early pharmacological treatment is recommended in these cases, as well as when life-threatening or severely disabling symptoms such as active suicidal ideation or acute psychosis occur. Without early intervention for severe psychiatric symptoms, treatment retention and remission of the SUD are unlikely to occur.

Nonadherence is common with COD and can be a major obstacle in achieving stabilization. Poor insight can be a significant challenge in those with SUD as well as with SMI and a person's acceptance of treatment or medication may not be possible until a modicum of therapeutic alliance is established. At this precontemplative stage, it is as important to take a motivational approach to the topic of medication as well as addiction treatment. Person-centered interventions are important and include shared decision making that emphasizes freedom of choice and individually defined reasonable risk taking; and discussing the persons' goals and fears regarding medication and addiction treatment. At later stages of change, routinely monitoring medication and collaborative problem-solving to improve adherence is indicated.

Pharmacotherapy for Mood and Anxiety Disorders with Co-occurring Addiction

Both tricyclic (McGrath et al. 1996) and selective serotonin reuptake inhibitor (SSRI) antidepressants (Carpenter et al. 2004) have been shown to be modestly effective in major depressive disorder in the setting of comorbid alcohol dependence. However, they do not significantly impact alcohol consumption. SSRIs have not been shown to reduce depressive symptoms with comorbid cocaine dependence (Cornelius et al. 1998), although tricyclics have shown some promise (McDowell et al. 2005). Despite this, SSRIs are still the most often prescribed treatment for depressive and anxiety disorders in COD clients. This is likely due to their improved tolerability and lower toxicity compared to tricyclic antidepressants. A recently published double-blind placebo controlled study of sertraline combined with naltrexone and CBT for treatment of co-occurring depression and alcohol dependence produced a remarkable *double* the abstinence rate compared to sertraline, naltrexone, and/or CBT alone (Pettinati et al. 2010).

Carbamazepine, valproic acid, and lithium are all commonly accepted treatments for co-occurring bipolar disorder as well as prophylaxis of mania in patients with addictive disorders (Brady et al. 2003), although patients with SUDs may have a less optimal response to lithium than those without (Tohen et al. 1990; Bowden 1995). Brady et al. (2003) propose this is due to lithium's well-known limited efficacy in rapid-cycling or mixed bipolar disorder which is common in patients with addiction and co-occurring bipolar disorder. Generally, valproic acid is considered the first line treatment for co-occurring bipolar disorder because of the favorable side effect profile and benefit in reducing anxiety and withdrawal effects (Brady et al. 1995, 2003). Given the reinforcing nature and high abuse potential of benzodiazepines in patients with COD, these are not recommended as first line treatments for mania.

Likewise, in treating co-occurring anxiety disorders, benzodiazepines are not recommended because of their reinforcing and addictive potential. Buspirone has no significant abuse potential and it has modest success in patients with anxiety disorders and alcohol dependence (Modesto-Lowe and Kranzler 1999). Although not well studied in this population, tricyclics, monoamine oxidase inhibitors, and SSRIs are treatments of

choice for anxiety disorders. However, given their much safer side effect profile, SSRIs are first-line treatments for co-occurring addiction and anxiety disorders. To provide quicker anxiolytic effect during this slow titration, many will prescribe alpha or beta blockers such as prazosin, clonidine, or propranolol or an anticonvulsant such as gabapentin until an antidepressant trial takes effect (Brady et al. 2003).

Pharmacotherapy for Psychotic Disorders

Emerging literature suggests that atypical antipsychotic medications and clozapine in particular may be associated with decreases in substance use (Brunette et al. 2006; San et al. 2007) and improve chances of smoking cessation in patients with schizophrenia (George et al. 1995). Integrated treatments combining medications with psychosocial treatments and active case management have shown best results (Mueser et al. 2003; Drake et al. 2008).

Use of Addiction Pharmacotherapy in Patients with Psychiatric Illness

In general, medications for relapse prevention and detoxification are frequently used similarly in patients without psychiatric conditions as well as patients with CODs. Patients with CODs may be more open to psychoactive medication and thus more open to consider medications for relapse prevention.

Pharmacotherapy for Alcohol and Opioid Dependence

There are currently four FDA-approved medications for the treatment of chronic alcohol dependence and three FDA-approved medications for opioid dependence discussed in detail below.

1. *Disulfiram.* By inhibiting aldehyde dehydrogenase, disulfiram causes accumulation of acetaldehyde after alcohol ingestion. An "alcohol-disulfiram reaction" is characterized by diaphoresis, flushing, nausea and vomiting, tachycardia, and headache. This aversive reaction motivates patients to abstain from alcohol, but can also lead to hesitation to adhere with pharmacotherapy. Disulfiram has greater benefit with monitoring of medication administration, but it has been reported to exacerbate mania and psychosis (Li and Shen 2008) and should be avoided in those with psychotic disorders unless symptoms are under good control with medication.
2. *Naltrexone*. Originally developed to treat opioid dependence, the μ-opioid antagonist naltrexone decreases the reinforcing effects of alcohol and has been shown to delay relapse to alcohol and delay the percentage of drinking days (Kranzler and Van Kirk 2001). It generally appears efficacious compared to placebo in reducing relapse to heavy drinking (Mann 2004; Bouza et al. 2004) as long as adherence is good. It has also been shown to be even more effective when combined with sertraline for co-occurring depression and alcoholism (Pettinati et al. 2010).

   Naltrexone is also FDA approved for treatment of opioid dependence and works by blocking the euphoric effects of opioids. It has a very high affinity for the μ receptor and effectively blocks the effects of opiates for up to 24 h. However, naltrexone does little to block opioid cravings that can be prominent and drive relapse. Introduction of this medication can precipitate an unpleasant withdrawal syndrome unless the clinician ensures the patient with chronic opioid use has been free of short acting opioids for at least 5 days and long acting opioids for 10 days. Patients with severe co-occurring mental illness, limited coping skills, prolonged periods of opioid dependence, high cravings, psychosocial instability, or previous failed attempts at abstinence-based treatment have higher chances of success with opioid-substitution treatment.
3. *Long-acting injectable naltrexone.* This agent is administered in a 360 mg monthly gluteal injection. It alleviates the problem of nonadherence, has been shown to be effective

compared to placebo in reducing heavy drinking (Garbutt et al. 2005), and has also recently been FDA approved for treatment of opiate dependence. Additional advantages of long-acting intramuscular naltrexone include less risk of hepatotoxicity and less nausea.

4. *Acamprosate.* Chronic alcohol use leads to compensatory upregulation of the brain's major excitatory system (glutamate) and downregulation of its major inhibitory system (GABA) as the CNS attempts to maintain homeostasis. Cessation of chronic alcohol use leads to withdrawal, characterized by glutamatergic hyperactivity and GABA hypoactivity. This imbalance can take several months to dissipate, leading to prolonged subsyndromal symptoms of alcohol withdrawal such as insomnia, dysphoria, anxiety and restlessness. Acamprosate is believed to help restore the balance between the glutamate and GABA systems, decreasing subsequent cravings and risk of relapse in early recovery. It also diminishes the amount of alcohol consumed by patients in treatment who do experience relapse and leads to higher total abstinence rates and longer time to relapse (Chick et al. 2003). Acamprosate's efficacy has been established in multiple randomized controlled European studies (Chick et al. 2003) though it failed to show efficacy in a recent large US clinical trial (Anton et al. 2006). This medication is started after a short period abstinence has been achieved, but there are no safety issues if the patient relapses on alcohol and acamprosate should be continued if relapse occurs. Although this does not limit use with CODs, all patients started on acamprosate should be monitored for suicidal thoughts since such thoughts occurred more frequently among acamprosate-treated patients than among placebo-treated patients in clinical trials.
5. *Methadone.* The objective of opioid substitution treatment is to reduce illicit opioid use and the negative effects on patients' physical health, mental health, and interpersonal and occupational functioning. Methadone, a μ opioid agonist has been an effective life-saving treatment with much better retention and clinical outcomes than psychosocial treatment alone (Mattick et al. 2003). Under federal law, only physicians working in federally regulated methadone programs can legally prescribe methadone for treatment of opioid dependence. Treatment in a methadone-maintenance program provides significantly increased support, structure and monitoring of patients than does treatment with buprenorphine in an office-based setting. Patients with limited coping skills, increased psychosocial instability, or increased psychiatric comorbidity such as severe COD are likely to do better with this more intensive treatment. Methadone tapering into abstinence-based treatment without relapse is difficult but possible for COD patients and they should be in remission from their psychiatric illness for the prior 12 months before initiating a voluntary taper.
6. *Buprenorphine.* Considered as efficacious as methadone for maintenance treatment of opioid dependence (Mattick et al. 2002), buprenorphine is a partial μ agonist with extremely high affinity for the μ receptor and was FDA approved in 2002 for the treatment of opioid dependence. It blocks the euphoric affects of abused opioids while relieving cravings through partial stimulation of the receptor. Due to its *partial* agonism, it has a ceiling effect for CNS respiratory depression—making it far safer than other opioids in overdose. However, the use of large doses of benzodiazepines can overcome its ceiling effect, leading to several isolated reports of deaths in Europe. Buprenorphine can be used for opioid substitution treatment in an office setting or in a COD program at a community mental health clinic. It is administered sublingually as a combination agent with the opiate antagonist naloxone in a ratio of 4 mg buprenorphine: 1 mg naloxone. Although single agent buprenorphine is quite reinforcing and has high abuse potential, the addition of naloxone (which is not absorbed sublingually) prevents people from trying to dissolve and inject the medication, since it induces withdrawal. This combination agent can be administered daily or every 48 h due to its long half

life. However, patients should not be started on it unless they are in moderate withdrawal and have been off short-acting opioids for at least 12 h, since the high affinity of buprenorphine for μ receptors and its partial antagonism will precipitate withdrawal by acutely "knocking" full agonists off of the receptor.

Pharmacotherapy for Stimulant Dependence

Several medications have shown initial promising results though none are currently approved for treatment of stimulant dependence. Modafinil has been shown to block cocaine-induced euphoria (Malcolm et al. 2006), decrease frequency of cocaine use, and improve abstinence rates (Dackis et al. 2005). However, it appears to be ineffective for cocaine combined with alcohol dependence (Anderson et al. 2009). Disulfiram (Carroll et al. 2004), topiramate (Kampman et al. 2004), gamma-vinyl GABA (Brodie et al. 2005), and baclofen (Shoptaw et al. 2003) have also shown promise for cocaine relapse prevention. For methamphetamine/amphetamine dependence, double-blind placebo-controlled trials using bupropion (Elkashef et al. 2008), modafinil (McElhiney et al. 2009), and naltrexone (Jayaram-Lindstrom et al. 2008a, b) have shown positive results.

Pharmacotherapy for Tobacco Dependence in People with Co-occurring Disorders

The overall tobacco abstinence rates in both psychiatric and substance abuse treatment populations are lower than the rate in the general population and efforts to integrate smoking treatment into COD programs are lacking. De Leon et al. (2005) reported that among people with co-occurring SUD and SMI, the cessation rate for alcohol and drugs was around 45%, while the cessation rate for smoking was 10%. The use of tobacco was not traditionally addressed in mental health or substance abuse treatment programs until the last decade when newer cessation methods have improved quit rates in both the general public and among smokers with mental illness (Hall and Prochaska 2009). A recent study of tobacco cessation in people with schizophrenia has demonstrated a much better success rate of 50% in a double-blind placebo controlled trial with combination pharmacotherapy (Nicotine Replacement Therapy (NRT) plus bupropion) and CBT (Evins et al. 2007). Varenicline, an alpha4beta2 nicotinic acetylcholine receptor partial agonist, approved by the US FDA in 2006 for smoking cessation demonstrates improved success rates over NRT and bupropion in the general population (Aubin et al. 2008) and among smokers with mental illness (Stapleton et al. 2007). However, there have been reports of an increased rate of psychiatric symptoms in people with mental illness with varenicline (Purvis et al. 2009). Suicidal ideation has also been rarely reported. This agent clearly needs to be further investigated in the COD population and should be used with caution in those with SMI. The most frequently reported psychiatric events during treatment in a general population included sleep disorder (1.6%), anxiety (1.2%), depression (1.1%), abnormal dreams (1.0%), and mood change (0.6%) (Kasliwal et al. 2009). Evins and Goff (2008) reported on a case series of varenicline for tobacco cessation in 19 stable patients with schizophrenia and demonstrated successful treatment in 13 of the 19 subjects with no evidence of worsening of psychiatric symptoms.

Conclusions

Integrated substance abuse treatment in the mental health center is essential given the prevalence of co-occurring addictive disorders in community psychiatry clients. Principles of integrated treatment are delineated on the AACP Web site and the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site also has a publication site which includes the Center for Substance Abuse Treatment (CSAT) (http://www.csat.samhsa.gov) page where Treatment Improvement Protocols (TIP) publications can be ordered at no cost. The authors highly recommend

the TIP 42 publication entitled *Substance Abuse Treatment for Persons with Co-occurring Disorders* (Center for Substance Abuse Treatment 2005), which is an evidence-based best practice guideline and provides a wealth of information from consensus panels of nationally known substance use experts and professionals in related areas of mental health, primary care, and social services.

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Case Management and Assertive Community Treatment

24

Richard J. Goscha, Charles A. Rapp, Gary R. Bond, and Robert E. Drake

Introduction

For nearly 50 years, case management has been the keystone of community mental health care for people with serious mental illnesses, essential for optimal treatment and support. Specific models of case management have emerged and evolved in response to inadequacies in systems of care at any particular time. Many of these models have been further refined as part of the evidence-based practices movement in an attempt to bind together an array of effective services called evidence-based practices. But much has changed in the past few years that will challenge the future development and effectiveness of case management. Basic social supports have eroded. People with mental illnesses have been shunted into the criminal justice system. Psychiatrists in community mental health centers have been marginalized. Medical comorbidities and early mortality have become salient and have probably increased. Insurance payments to the pharmaceutical industry and to managed care companies have increased while payments for psychosocial supports have decreased. And at the same time that services have deteriorated, expectations have increased!

In this chapter, we trace the history of mental health case management, review the evidence for specific models of case management, enumerate general principles of effective case management, and discuss the current challenges regarding case management in a rapidly changing health care environment.

History

During the era when people with psychiatric disabilities spent considerable periods of their lives in asylums and psychiatric hospitals, all the available services were under one roof. Deinstitutionalization began in the 1950s despite the dearth of community-based services. Subsequently, the Community Mental Health Centers Act of 1963 established local mental health service providers throughout the United States. A limited array of services was mandated with an emphasis on counseling, partial hospitalization/day treatment, and medication management. Many people discharged from the hospital lived in urban ghettoes or with overwhelmed families. The narrow range of supports was clearly inadequate to sustain a person in the community, and the "revolving door" of psychiatric hospitalization became the de facto course of treatment for many. Furthermore, people living in the community were poor and lonely, lacked

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decent housing, and had few opportunities for meaningful activity (Draine et al. 2002).

The Community Support Program (CSP), initiated by NIMH in 1977, sought to increase the support services available to people with psychiatric disabilities. CSP recommended and helped establish a wide range of support services, including crisis stabilization services, vocational services, various forms of housing, daytime and evening activities, support to families, and assistance in accessing entitlements. This range of services, while badly needed, added considerable complexity for clients and families to arrange access and coordinate efforts often from multiple organizations and service providers. Case management was included in CSP to assure the continuous availability of individualized assistance (Turner and TenHoor 1978).

The earliest model of case management, the broker model, sought to coordinate care by linking clients to services based on an assessment of need; services included planning, monitoring, and advocacy (Intagliata 1982). A single entity would be responsible for organizing access to needed services from a fragmented and complex service system—largely an administrative function. The distinguishing characteristic of the broker model was that its central purpose and method was to link people with formal mental health services and entitlements (Curtis et al. 1992). The assumption was that once services were accessed a person would be able to live more independently and their quality of life would improve. In the early 1980s, Medicaid began reimbursing states for broker model case management (Hogan 1999).

Thus, case management was originally intended to coordinate care through referrals to needed services. But the broker model was based on the faulty premise that needed services were in fact available in the community. Its disappointing results (see section "Research on Case Management") were, in part, due to the poor quality and effectiveness of available services. Evidence-based practices, interventions with the most robust empirical support, were not available in most settings. Even today, availability and access are minimal (Drake and Essock 2009). Another weakness in the broker model was the requirement that clients engage with a complex and bureaucratic service system. Again, engagement remains a huge barrier to effective treatment today (Kreyenbuhl et al. 2009).

In contrast to the broker model, several more clinical approaches developed in which case managers built relationships with clients and directly delivered some services while coordinating others. The broker function became but one component of a more complete version of case management. Two approaches, Assertive Community Treatment (ACT) and Intensive Case Management (ICM), focused primarily on structural aspects of the service model, such as low caseloads, outreach mode of service delivery, etc. ACT has been specified in several manuals (Allness and Knoedler 2003; Test and Stein 1976).

ACT and ICM were designed for clients with high use of inpatient and emergency room services or other high-need target populations (Surles and McGurrin 1987). Although ICM does not have a single agreed-upon definition, some common features include the following: low caseloads; assertive outreach including home and community visits; tangible supports for income support, housing, transportation, and activities of daily living; and a focus on preventing unnecessary psychiatric hospitalizations (Schaedle and Epstein 2000). While similar to ACT, ICM does not prescribe the team structure and shared caseloads, nor does it even necessarily involve a team.

Clinical Case Management and Rehabilitation Case Management further elaborated the case manager's clinical activities. (In both models, case managers also brokered some services.) Clinical Case Management emphasized individual psychotherapy or counseling, living skills training, and psychoeducation (Kanter 1989, 1996; Walsh 2000); Rehabilitation Case Management stressed teaching living skills (Farkas and Anthony 1993).

Another direct service model, the Strengths Model, emerged in the mid-1980s as an antidote to traditional deficit-based approaches. The Strengths Model contained structural and clinical

prescriptions as well as standards for supervision of case managers (e.g., review of practice tools, feedback, field mentoring). Structural features included caseload size not to exceed 20:1, use of group supervision, and outreach for service delivery. Clinical components included specific tools and methods to help clients set meaningful and important recovery goals, and to emphasize the strengths of the client and the environment in order to achieve these goals. In contrast to both Clinical and Rehabilitation models with their focus on changing the individual (e.g., gaining insight, learning skills), the Strengths Model focuses on finding, creating, and supporting opportunities for people that match their goals and aspirations (Rapp and Goscha 2006).

Research on Case Management

Broker Model

The broker model has failed the test of evidence-based practice. At least nine experimental or quasi-experimental studies of the broker model have been published (Bigelow and Young 1991; Curtis et al. 1992; Edwards et al. 1991; Franklin et al. 1987; Hornstra et al. 1993; Jerrell and Ridgely 1995; Lehman et al. 1994; Muller 1981; Rossler et al. 1992). These studies have generally found *increased* use of psychiatric hospitalization (Curtis et al. 1992; Franklin et al. 1987) and no differences in quality of life (Curtis et al. 1992; Lehman et al. 1994). Eight of the nine studies found no advantages for the broker model.

Assertive Community Treatment

Over the last three decades, ACT has proven to be a robust treatment model for people with severe mental illness. The model's features have been clearly described (McGrew and Bond 1995) and measured by a fidelity scale (Teague et al. 1998). In the United States, ACT has been identified as an evidence-based practice by expert panels (Drake et al. 2001; Kreyenbuhl et al. 2010), endorsed in federal reports (New Freedom Commission on Mental Health 2003; Surgeon General 2000), and vigorously advocated by the National Alliance on Mental Illness (Allness and Knoedler 2003).

ACT has also been extensively studied. A 2001 review located 25 randomized controlled trials (Bond et al. 2001); probably at least that number of studies have been conducted since then. Of the many relevant reviews conducted since 1998 (Baronet and Gerber 1998; Bedell et al. 2000; Bond et al. 2001; Burns et al. 2007; Coldwell and Bender 2007; Corrigan et al. 2008; Gorey et al. 1998; Herdelin and Scott 1999; Latimer 1999; Marshall and Creed 2000; Mueser et al. 1998; Nelson et al. 2007; Scott and Dixon 1995; Smith and Newton 2007; Ziguras and Stuart 2000), some have focused specifically on ACT, whereas other reviews have broadened their focus to include any ICM model. Despite this heterogeneity, the reviews generally agreed on several key findings.

First, ACT increases community tenure for clients with extensive psychiatric hospitalizations. Second, ACT improves residential outcomes, though the specific measures in this domain have been diverse and have included reduction in homelessness, residential stability, independence of housing arrangement, and other indicators. ACT is particularly effective for clients with the high rates of hospitalization (Burns et al. 2007) and for those who have been homeless (Coldwell and Bender 2007). Third, ACT sustains engagement in treatment (Bond et al. 1995). Fourth, ACT clients and their families express higher satisfaction with services (Mueser et al. 1998). Fifth, ACT enhances self-reported quality of life (Bond et al. 2001).

The evidence for ACT is negative or mixed on a number of other domains, including symptoms, substance use, employment, criminal justice involvement, and social functioning (e.g., Bond et al. 2001; Mueser et al. 1998). To improve these other outcomes, ACT must be augmented with interventions specific to these domains. For example, to address co-occurring substance use disorder, ACT teams should employ substance abuse specialists and incorporate evidence-based principles of integrated dual disorders treatment

(Drake et al. 2008). Similarly, ACT should incorporate supported employment to improve employment outcomes (Bond et al. 2008).

ACT has recently been modified in several ways. Because increasing numbers of clients with psychiatric disabilities are now involved in correctional systems, ACT has been used to serve this population and to reduce recidivism. Early ACT studies generally found no impact or negative outcomes in this area. A newer forensic ACT model (Lamberti et al. 2004; Morrissey et al. 2007) has minimal research (Cusack et al. 2010). Historically, state mental health authorities promoted ACT in the interests of reducing institutional care (Mowbray et al. 1997). Another change has been to emphasize the recovery orientation of ACT (Salyers and Tsemberis 2007), for example, by augmenting ACT teams with Illness Management and Recovery (IMR) services (Mueser et al. 2002), another evidence-based practice. A recent study combining ACT and IMR yielded inconclusive results (Salyers et al. 2010).

Given the proliferation of case management services labeled as ACT but departing from the original model, several research groups have developed fidelity scales (McGrew et al. 1994; Teague et al. 1995). The most widely used ACT fidelity scale is the DACTS (Teague et al. 1998). A recent update of that scale is more comprehensive (Bjorklund et al. 2009). Fidelity to the ACT model is modestly associated with better outcomes (Bond et al. 2001; Burns et al. 2007; Latimer 1999).

In contrast to the positive reviews of ACT in the United States, researchers outside the United States have criticized the ACT model (Burns 2000; King 2006; van Veldhuizen 2007). In the UK, for example, several large ACT trials yielded null findings, leading British researchers to question the effectiveness of ACT when compared to competent standard services. King (2006) noted that much of the evidence for ACT (and ICM) is out of date, and some recent ACT trials have found no differences compared to standard services in high-resource states (Drake et al. 1998). Van Veldhuizen (2007) developed and evaluated a hybrid model of ACT prompted by the inadequacies of the standard ACT model for rural settings. Another concern regarding ACT has been the lack of clear plans to transfer clients over time, based on the original ACT prescription of lifetime services, which limits the capacity of ACT to admit new clients. These concerns remind us of the need to continuously reevaluate and to modify service models to respond to new conditions and populations, and to challenge untested assumptions (Bond and Drake 2007).

Strengths Model

Besides ACT, the most widely studied case management approach is the Strengths Model. Nine studies have tested the effectiveness of the Strengths Model with people with psychiatric disabilities. Four of the studies employed experimental or quasi-experimental designs (Modrcin et al. 1988; Macias et al. 1994, 1997; Stanard 1999), and five used nonexperimental methods (Rapp and Chamberlain 1985; Rapp and Wintersteen 1989; Ryan et al. 1994; Kisthardt 1993; Barry et al. 2003). These studies produced positive outcomes in the areas of hospitalizations, housing, employment, reduced symptoms, leisure time, social support, and family burden.

In the four experimental studies, positive outcomes significantly outweighed the outcomes in which no significant difference was reported. In none of the studies did clients receiving Strengths Model case management do worse. The results have also been remarkably consistent across settings and within studies. Three of the studies had multiple sites with different case managers, supervisors, and affiliations, with a total of 15 different agencies.

The two outcome areas in which results have been consistently positive are reduction in symptoms and enhanced quality of community life. All three studies assessing symptom outcomes reported statistically significant differences favoring the Strengths Model. This included findings that people receiving Strengths Model case management reported fewer problems with mood and thoughts, and greater stress tolerance and

psychological well-being than the control groups. In one study that compared ACT and the Strengths Model, no differences were found in hospitalization and social functioning but statistically significant differences favoring the Strengths Model were found for symptomatology (Barry et al. 2003).

Although the studies used a variety of measures (e.g., increased leisure time in the community, enhanced skills for successful community living, increased social supports, decreased social isolation, and increased quality of life), people receiving Strengths Model case management had enhanced levels of competence and involvement in community living. Eight of the nine studies using these types of measures reported statistically significant positive outcomes.

Other outcomes that seem to be strong indicators of the effectiveness of Strengths Model case management include reduced hospitalization (three out of six studies showing positive outcomes), vocational (two out of two showing positive outcomes), and housing (two out of two showing positive outcomes).

The research on Strengths Model case management is suggestive of its effectiveness. On the downside, the research is limited to two experimental, two quasi-experimental, and five nonexperimental studies. The size of the samples in three of the experimental studies was small. The measures used across studies varied and questions have been raised about many of these measures (Chamberlain and Rapp 1991).

Other Case Management Models

There have been no studies of the effectiveness of clinical case management. The effectiveness of the Rehabilitation model is limited to one quasi-experimental study (Goering et al. 1988). An appraisal of the effectiveness of ICM is complicated by the lack of a standard, commonly accepted meaning of the term, "intensive case management." Some reviewers have used ICM as a broader rubric to include ACT as well as other variants of ICM. On closer examination, the majority of studies commonly included in these reviews are in fact ACT studies. To our knowledge, no review has expressly examined non-ACT ICM studies as a subcategory. Moreover, no rigorous head–head comparisons between ACT and ICM have been reported in the literature.

Barrier to the Effectiveness of Case Management

Today multiple changes in society and in the health care system impinge on and seriously challenge effective case management. To curtail costs, case management is often managed itself by managed care agencies. These organizations provide pressures for efficiency, documentation, and reimbursable service units and thereby make it difficult for case managers to perform many effective services, such as outreach, helping people find jobs, and building relationships slowly with people who have difficulty trusting others. Medicaid is the primary funding source for community mental health services including case management. The definition of "targeted case management" in Medicaid closely conforms to the broker model. In order to reimburse other case management models, states have to request a waiver or rename case management as a different service (e.g., community psychiatric support and treatment). In fee-for-service systems through Medicaid, billable case management activities are encouraged but others are not permitted. Examples often excluded are work with natural community resources, transportation to appointments, and outreach.

Many case managers are increasingly working in isolation from other key professionals within community mental health centers. Cost cutting has in some cases eliminated frontline supervisors or has raised the number of case managers per supervisor to an extent that support is minimal. Training has also eroded for many case managers as a result of cost-saving measures.

Case managers today are also facing new and increasingly difficult challenges without adequate resources to combat them. Basic social services, including housing subsidies and vocational services,

have eroded. Thus, homelessness, drug abuse, victimization, and health problems, such as HIV and hepatitis infections, have worsened. People with mental illness are increasingly shunted to the criminal justice system, resulting in further stigma, abuse, and health insurance problems. Overmedication, polypharmacy, poor health behaviors, comorbid medical illnesses, lack of or inadequate medical care, and early mortality have become more salient and probably more prevalent.

Case management is expected to solve all of these problems and more. The expectations have risen from merely helping clients achieve stability and maintenance in the community to helping people achieve significant levels of recovery, which entails helping people achieve meaningful and important life goals. These increased demands have been accompanied by salaries that have been stagnant for years, less ongoing training and supervision, and fewer contacts with psychiatrists and other professional colleagues. Is it any wonder that job satisfaction is low and that job tenure of case managers is so brief (about 18 months across the United States, Woltmann et al. 2008)? The public mental health system is a shambles (New Freedom Commission 2003; NAMI 2006), and case management as a profession is parlous. Health care reform will undoubtedly produce new forms of mental health care, which will, we hope, revitalize and strengthen case management.

The Basics of Effective Case Management

Despite the challenges, case management can be a valuable and effective service when implemented properly. Several basic aspects of effective case management are clear from the past decades of experience and research. As we look to strengthen case management in today's environment, the following principles will need to be salient in health care reform and in emerging mental health structures.

1. Direct service delivery

   This ingredient was present in each of the nonbroker model studies reviewed. In contrast, common to each of the broker model studies is the reliance on referral, especially to mental health services (Curtis et al. 1992; Franklin et al. 1987; Hornstra et al. 1993). ACT and the Strengths Model prescribe that case managers should directly provide most of the services. Due to the fragmented nature of many mental health systems, this principle serves many practical purposes. Many people with psychiatric disabilities have difficulty navigating the large array of supports they may need. This becomes extremely difficult in agencies where life domains are carved out among multiple specialists. For example, some agencies may have a housing specialist, employment specialist, education specialist, substance abuse specialist, life skills specialist, etc.

   An important aspect of this principle is that case managers remain integrally involved with their clients' goals, and negotiate their role relative to other providers' involvement. For example, while we do not expect case managers to prescribe or offer advice around psychiatric medications, they could still have a role when a client has a goal to find a medication that offers relief from distressing voices. Case manager roles might include: assisting the client to write specific questions they had for their doctor, helping the client write specific side effects they find uncomfortable, and accessing information on nonmedical methods of controlling voices (e.g., headphones, distracting techniques, etc.).

   This principle does not preclude these types of specializations. In fact, having a Supported Employment specialist on the team is likely to increase employment outcomes for clients (Gold et al. 2006). What this principle does suggest is that the case manager should have a central role even when a specialist is involved. For example, if a person is referred to Supported Employment because of an employment goal, the case manager would still be highly involved in the goal despite the referral. While the Supported Employment worker might assume high-skilled specialized roles (i.e., job development, vocational assessment, negotiating accommodations, etc.), the case manager could assist the client with other tasks around this goal that did not need this level of specialty

(e.g., developing a plan for getting to and from work, purchasing supplies or clothes needed for job, developing symptom self-management strategies, arranging child care, etc.).

2. Service delivery in the community
An outreach style of service delivery is prescribed by both ACT and Strengths (Rapp 1993; Test 1992; Witheridge 1991). There are multiple reasons for this principle. First, consumers highly value assistance with everyday problems (e.g., transportation, assistance in obtaining housing and living resources, assistance with medical care, etc.) (McGrew et al. 1996) and this has been found to be correlated with consumer satisfaction (Huxley and Warner 1992). This is consistent with the idea that tangible forms of help are the most powerful in helping clients avoid rehospitalization (Bond et al. 1990). These life tasks occur in the community context where the help needs to be provided: in apartments, restaurants, businesses, parks, and community agencies. If client self-determination was taken seriously, in vivo service delivery would be the norm since most clients prefer it (Rapp and Goscha 2006).

Second, work in the community minimizes dropouts and enhances engagement. The evidence is overwhelming. ACT research consistently finds rates of retention for at least a year to exceed 80% (Bond et al. 1995), which is considerably higher than the less than 50% for even 6 months found for traditional aftercare (Axelrod and Wetzler 1989; Bond et al. 1995). ACT and Strengths experts both rated the importance of outreach and in vivo service delivery very highly (McGrew and Bond 1995; Marty et al. 2001).

Third, work in the community assures that skills are being learned in the context in which they will be performed thereby avoiding problems of generalization. There is little behavioral evidence that skills learned in one venue transfer to others (Bellack 2004; Gutride et al. 1973; Jaffe and Carlson 1976; Liberman et al. 1985).

Fourth, work in the community allows more complete and accurate assessments. A person's behavior is context-specific. People often behave differently in mental health programs than they do in community settings. The behavior of interest is that of the community not the behavior that occurs in contrived mental health programs surrounded by staff with their own culture and set of rules.

Fifth, and perhaps most importantly, the evidence strongly suggests that in vivo service leads to reductions in hospitalization. Bond (1991) commented that "one program using office visits because of a reluctance to make home visits had minimal success until it changed its treatment strategy" (p. 75). In a multisite study, Rosenheck et al. (1995) found that one site that provided intensive services, but did not provide them in community settings, actually increased both inpatient usage and costs by more than 50%.

3. Natural community resources
Natural community resources refer to nonformal, nonsegregated resources provided by landlords, ministers, employers, teachers, community colleges, neighbors. The primacy of this ingredient is consistent with notions of recovery that emphasize building a life apart from the mental health system (Ridgway 2001). In fact, community integration has been viewed as a centerpiece of recovery where "people with disabilities live, work, play and lead their daily lives without distinction from and with the same opportunities as individuals without disabilities" (Bond et al. 2004, p. 570).

ACT and the Strengths Model encourage case managers to do this rather than make referrals to specialized programs. In fact, the fidelity scales for both models have an item directed to this dimension (Rapp and Goscha 2006; Teague et al. 1998). For example, working with employers rather than using a sheltered enclave or reaching out to landlords rather than referring to a mental health run housing program. The need for such an approach is obvious in rural areas that typically lack formal services. The results in rural areas of this approach for both ACT and Strengths found significantly lower rates of hospitalization and high rates of goal achievements in most life domains (Rapp and Wintersteen 1989; Santos et al. 1993).

4. Small caseloads
   The expectations concerning the direct provision of services, the outreach mode of service delivery, involvement with crises, highly individualized service, the breadth of life domains to be attended to, and the work with naturally occurring resources inevitably requires a relatively low consumer to staff ratio. Low ratios received virtuously unanimous agreement of ACT experts (McGrew and Bond 1995). Davidson et al. (2006) views high caseload sizes as a concern in terms of the ability for mental health programs transformation to recovery oriented care. ACT programs recommended a 10:1 ratio (Test 1992; Witheridge 1991). The Strengths Model suggests caseload sizes between 12:1 (Rapp and Wintersteen 1989) and 20:1 (Macias et al. 1994). Mueser et al. (1998) recommends a case load size of 20–30:1. In two studies where the comparison to the ACT team had lower caseloads (Bond et al. 1991; Sands and Cnaan 1994) there were no significant differences in hospitalization outcomes.

   Caseload sizes exceeding 20:1 are also contraindicated for working with individuals with complex needs, including individuals who have substance abuse disorders, cognitive, and/or physical disabilities in addition to a mental illness. Traditional mental health programs have focused on symptoms reduction and stable living status as means of evaluating the effectiveness of their services. First person accounts of recovery reveal that people with psychiatric disabilities desire more than just having the ability to cope and maintain, but instead desire the achievement of goals that bring meaning, purpose, and identity to their lives. Case management services that are reactive and/or crisis oriented are incongruent with this approach. High caseloads sizes limit case managers' ability to offer individualized services.

   Both ACT and the Strengths Model suggest tailoring caseload size to the needs presented by people and the outcomes or benefits sought by the intervention. For example, ACT recommends a 12:1 ratio when the caseload comprises only people with high hospital utilization or who are homeless. A ratio of 20:1 seems effective when it comprises people normally distributed in terms of severity (Macias et al. 1994) and 30:1 if comprising people who are stable and more independent (Salyers et al. 1998).

   Three key points are salient here. First, frequency of contact rather than hours of contact makes a difference (McGrew et al. 1994; Rife et al. 1991); the use of telephone may be a helpful supplement, not a replacement. Second, frequency of contact and hospital outcomes will never be truly linear since those who are most in need will often receive the most contact but may also have higher rates of hospitalization (even if reduced compared to similar control groups). Third, the quality of the contact, not just frequency, is a mitigating factor. For example, small caseloads employing ineffective methods or unskillful case managers would probably be ineffective. The study by Hornstra et al. (1993) is illustrative whereby a broker model intervention with small caseloads and significantly more case manager contact produced no outcome differences compared to the control group.
5. Case managers and supervisors
   In the Unites States, case managers are mostly bachelors-level staff without education in one of the helping professions. Both ACT and the Strengths Model use teams of generalists with consultation by medical professionals and other experts as needed. Recommended experts would include employment specialists (Furlong et al. 2002; Gold et al. 2006; Bond 1998) and dual diagnosis experts (Drake et al. 2001). ACT research has found that nurse participation on the team was correlated with positive outcomes (McGrew et al. 1994).

   There is considerable evidence that a wide range of people can be effective case managers including students (Modrcin et al. 1988; Rapp and Chamberlain 1985; Rapp and Wintersteen 1989) and consumers. One recent review concluded that studies of consumer-delivered services report equally positive outcomes as traditional services, particularly for practical outcomes such as employment, income, education, or living arrangements (Doughty and Tse 2011) which echoed an earlier review by Davidson et al. (2006). The key seems to be the competency level of the staff person

delivering the service. The Strengths Model prescribes a list a behaviors and competencies that need to be performed in order to achieve high fidelity (Rapp and Goscha 2006). Staffs are able to attain the needed skills to achieve proficiency in the model through structured teaching methods employed by the supervisor.

The lack of professional training and relatively high turnover rates among case managers is compensated, in part, by having high quality supervision from a seasoned professional. In fact, the Strengths Model fidelity scale devotes one section to supervisory behaviors including group supervision of the team, field mentoring and quality review of tools (Rapp and Goscha 2006). Adopting a consumer outcome-based supervisory style has been recommended (Rapp and Goscha 2006). In addition, access to in-service training and technical assistance has been recommended (Bond et al. 1990).

6. Choice
The freedom to choose has been a stated value of community services for over a decade. In fact, self-determination and choice has been one of the six principles of the Strengths Model since its inception in the early 1980s. More recently, choice has become an integral part of the shared decision-making movement and its methods. The principle of choice is important considering research showing that people with psychiatric disabilities prefer active and collaborative roles in terms of health care decisions (Hamann et al. 2006; Adams et al. 2007). People with psychiatric disabilities who are able to actively participate in designing their own treatment plans are more likely to have an improved self-image, to be satisfied with the services they receive, and achieve their treatment goals (Chinman et al. 1999). In a qualitative study on conditions that need to be present for client empowerment to occur through treatment planning, Linhorst et al. (2002) found that providing the client a range of treatment options was critical. In addition, it was noted that these options "must support the achievement of clients' self-selected goals" (p. 432).

There is an increasing body of research suggesting choice is also associated with improved outcomes. In Supported Employment, interventions that base admissions merely on a person's desire to work and which individualize job seeking to positions conforming with people's preferences produce higher rates of competitive employment (Abrams et al. 1997; Becker et al. 1996; Gowdy et al. 2003; Mueser et al. 2001).

In a review of supported housing research, Ridgway and Rapp (1997) found that when people had subsidies and options, most moved into independent living situations (Depp et al. 1986; Dixon et al. 1994; Newman et al. 1994). In a ten-site pre–post national evaluation, increased sense of choice at baseline was found to be associated with improved satisfaction with housing and improved residential stability at follow-up (Livingston et al. 1991; Srebnick 1992).

The importance of choice is also seen in motivational interviewing strategies used in integrated dual diagnosis treatment (Carey 1996; Drake et al. 2001; Miller and Rollnick 2002; Ziedonis and Trudeau 1997). For example, it is the practitioner's role to elicit "change-talk," provide information, and clarify the client's thinking, but all decision-making rests with the client. The importance of choice also resounds from the hundreds of first person accounts of recovery.

7. Full-time access
Each model argues that case managers should be accessible 24 hours a day, 7 days a week and most experimental conditions included this element. One of the reasons for team approaches is to spread this responsibility across team members. The ACT experts, however, reached relatively low levels of agreement on this element while the early Wisconsin efforts and some subsequent ACT programs adhere to this rigidly. Some ACT programs operate during business hours only. Even with great variation in this dimension across studies, positive outcomes have been reported regardless of the structure employed; therefore, this specific component of service seems optional.

What is not optional is that people need access to crisis and emergency services, 24 hours a day, 7 days a week. The effectiveness of crisis services is enhanced by in-person or phone

access to staff who have familiarity and a relationship with the person and who are committed to avoiding hospital care when possible (Carlson et al. 1998). This would necessarily include the case manager, the team leader or supervisor, the team members, or in some small (probably rural) areas the crisis staffs themselves.

Psychiatric Epidemiology

Throughout the United States, case management services are inadequate (Wang et al. 2002). In usual practice, only 2% of clients receive case management services approximating ACT (Lehman et al. 1998). Budget constraints have led to the de facto adoption of brokered case management with high caseloads, in which clients are referred to other programs and agencies for housing, employment, and other services. Individual caseloads averaging about 30 clients are common (Boyer and Bond 1999; Ellison et al. 1995), but this average camouflages much larger caseloads, ranging up to 300:1 (Ellison et al. 1995). As noted above, brokered case management with high caseloads is not only ineffective but contributes to deterioration in client functioning (Rapp and Goscha 2004).

It has been long been recognized that case management services should be titrated to the level of client need (Giesler and Hodge 1998). At one extreme would be people who are acutely psychotic, dangerous to themselves and others, and/or are not lucid. Their lives are often in "survival mode" just trying to eke out an existence day by day. A middle group is in the process of recovering their lives and have goals (whether modest or not) where the disability impedes progress. The other end of the continuum contains people who are stable, living their lives in ways that bring them satisfaction despite the disability. In light of health care changes in the United States, it remains an open question how to allocate resources to staff such tiered services, and whether to incorporate step-down mechanisms and hybrid models established to respond to fluctuating needs (Salyers et al. 1998; van Veldhuizen 2007).

A fundamental ACT principle is targeting a circumscribed population: adults with SMI who do not benefit from usual care (e.g., clients with a history of frequent or long-term hospitalizations, co-occurring substance use disorders, homelessness, involvement with the legal system, or other indicators of not benefiting from less intensive services). According to this view, ACT is appropriate for people at the most severe disability end of the continuum, and not appropriate for the large majority of clients with SMI in the public mental health system, in part because of resource issues. Specifically, ACT is not cost-effective if provided to clients with SMI without regard to service need (Burns et al. 2007; Latimer 2001). Two basic questions, then, are the following: *What proportion of the SMI population should receive ACT? What kind of case management services should be provided to clients not receiving ACT?*

Two recent studies have sought to address the question of needed capacity for ICM/ACT services in a given geographic area. Using traditional ACT hospitalization criteria, their estimates ranged from 50% (Cuddeback et al. 2006) to 80% (van Veldhuizen 2007) of all clients in the service area—which would be prohibitive from a resource perspective. These estimates are based on a generally outdated premise that ACT teams are designed primarily to serve frequently users of psychiatric hospitals, which was the primary mission for ACT in the 1980s (Bond et al. 1995; Mowbray et al. 1997). Because of deinstitutionalization, far fewer clients are hospitalized at any time and inpatient stays are now much shorter in the United States (Lamb and Bachrach 2001). Thus, the original mission for ACT has been largely eclipsed, except in countries such as Japan, where deinstitutionalization has not yet occurred (Ito et al. 2009).

Another complicating factor in ACT eligibility estimation is that ACT services do not exist in a vacuum. Inadequate basic mental health services (e.g., housing, other community support services, crisis services) may lead to clients' deterioration and increased need for ACT. Since people often stay on ACT teams for prolonged periods of time, ACT services become unavailable for new clients. So this begs the question: what should case management services look like for the remainder of the SMI population?

The Strengths Model was primarily designed for those individuals who still experience significant barriers and challenges to goal achievement because of the disability, but do not require the intensity of services like ACT. While Strengths Model philosophies, tools, and methods can be used within ICM services, the model is most applicable to the middle group mentioned above. Using the data from the two studies above (Cuddeback et al. 2006; van Veldhuizen 2007), 50–80% of all people in a service area could benefit from Strengths Model services. The clients served by the Strengths Model in the research conform to the parameters of this middle group.

Prevention

The case management services described in this chapter aim at preventing negative outcomes such as psychiatric crises, unnecessary psychiatric hospitalizations, and homelessness. Case management services are most effective when they are proactive, ensuring that clients have basic resources and access to needed psychiatric services and that they have developed relapse prevention strategies, all of which help prevent negative outcomes. The extent to which different case management approaches have been successful in preventing negative events has been discussed above.

One other important area of prevention, not discussed in this chapter, is prevention of disability through early intervention with clients experiencing their first episode of psychosis (Killackey et al. 2006). In this population, duration of untreated psychosis is negatively associated with outcome (Marshall et al. 2005). One goal of early intervention programs for this population is to bypass the cycle of decline that leads clients to applying for Social Security disability benefits accompanied by the formation of an identity as a disabled person (Estroff et al. 1997). The National Institute of Mental Health is supporting large-scale research on identifying the critical ingredients of a package of services to address the needs of this population (Hsiao 2008). The service model will likely include strengths-based case management and assertive outreach, in addition to supported employment and supported education and other interventions.

Advocacy

The hallmark of the effective case management approaches is advocating for clients with regard to their personal goals. The advocacy often takes the form of facilitating acquisition of community resources—to competitive jobs, community housing, recreational services, and the like. Given the importance of using naturally occurring resources, advocacy targets a wide range of people and organizations that control resources needed or desired by clients. There are four dimensions of resource advocacy: availability, accessibility, accommodation, and adequacy. Availability refers to the presence of a needed resource. Accessibility relates to the ability of the client to make use of the available resources which could include consideration of transportation, entrance requirements or prerequisites for use, cost, etc. Accommodation addresses possible adaptations that may be needed for the client to make use of the resource. In employment, examples could include hours, frequency of breaks, or the actual structuring of work duties. Lastly, adequacy refers to how well the resource meets the needs of each particular person. Is it contributing to personal fulfillment and satisfaction or to the achievement of their personal goals?

While negative strategies (e.g. threatening to sue, involving the media) are occasionally necessary, most successful advocacy efforts are relationship based and assume that most people are open to helping people with psychiatric disabilities (Rapp and Goscha 2006). For example, advocating for employment for a client is best served by a job development approach that seeks to build a relationship with the employer (Carlson et al. 2008; Bissonnette 1994).

Conclusions

Case management has been a central feature of community mental health care for people with serious mental illnesses for nearly 50 years.

An accumulated evidence base strongly supports the effectiveness of specific models of case management, especially ACT and the Strengths Model, and of several basic elements of case management, such as direct delivery of services in the community.

Nonetheless, challenges to evidence-based case management are legion: social and economic changes in society, criminalization of people with mental illness, erosion of support services, pressures for cost control, high prevalence of medical problems, and health care reform. As new forms of community mental health care emerge, case management will inevitably be affected. The lessons of the past 50 years should critically inform the reconstruction process.

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25 Supported Employment

Kim T. Mueser and Gary R. Bond

Introduction

Most clients with severe mental illnesses (SMI) such as schizophrenia and treatment refractory major mood disorders want to work (Frounfelker et al. 2011; McQuilken et al. 2003; Mueser et al. 2001b), but fewer than 15% within the public mental health system are currently employed (Lindamer et al. 2003; Rosenheck et al. 2006; Salkever et al. 2007). Employment is typically a goal because it provides structure, daily activity, meaning, a normal adult role, social contact, community integration, self-esteem, increased income, and better quality of life (Bond et al. 2001a, b; Burns et al. 2009). Moreover, more than two thirds of individuals with SMI live in poverty (Draine et al. 2002). Employment income can help reduce this source of misery.

Clients with SMI are often demoralized, but fearful about the consequences of working. Yet most yearn to lead normal lives, to be part of general society, and to be productive (Maslow 1970). As Beard et al. (1982) noted, a job is a place where you are *needed*; if no one depends on you showing up, then why even bother getting up in the morning?

Among the many different vocational approaches described in the literature, few have been adequately described, and, with one exception, none have a systematic body of rigorous research showing effectiveness in increasing competitive employment rates (Bond 1992; Bond et al. 1999; Crowther et al. 2001; Honey 2000; Lehman 1995; Schneider et al. 2002). In this chapter, we describe supported employment, one practice that has demonstrated effectiveness in helping clients with SMI gain competitive employment.

Principles of Supported Employment

The most thoroughly standardized approach to supported employment for persons with SMI is the Individual Placement and Support (IPS) model, which was first described in a manual in 1993 (Becker and Drake 1993), and subsequently revised a decade later (Becker and Drake 2003). According to the IPS model, supported employment is defined by a core set of principles that are reflected in all of the services provided. These principles include the following: zero exclusion criteria, focus on competitive employment, integration of vocational and clinical services, benefits counseling, attention to client preferences, rapid job search, and provision of follow-along supports. These principles are all supported by empirical research (Bond 1998, 2004).

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Zero Exclusion Criteria

Neither clinicians nor researchers can accurately predict which persons with SMI can obtain competitive work. Therefore, not excluding clients who want to work based on other criteria maximizes the chances that supported employment will be available to the greatest number of clients who may potentially benefit from it. The only criterion for including a client in a supported employment program is that the individual wants competitive employment. Thus, exclusion criteria for participation in supported employment, such as substance abuse, clinical stability, medication adherence, cognitive impairment, or time since last hospitalization, are not used to rule out clients who express an interest in work.

Focus on Competitive Work

Most people with SMI want competitive jobs in integrated community settings, rather than shelter jobs that often pay below minimum wage. The Substance Abuse and Mental Health Services Administration has defined competitive employment as work in the community that pays at least minimum wage and that has not been specially reserved for people with a disability (Cook et al. 2005a, b). Supported employment honors this preference by focusing only on competitive work, in contrast to other vocational approaches, which may emphasize sheltered work as a steppingstone to competitive work, or transitional employment, in which individuals work at jobs in the community that have been secured by the agency providing the vocational services and are owned by that agency, in order to develop their work experience and resumes before moving on to competitive jobs.

Integration of Vocational and Clinical Services

There are several advantages to fully integrating supported employment and clinical services for persons with severe mental illness. First, the integration of services maximizes the chances that the client's clinical treatment providers will support the client in pursuing his or her vocational goals. Second, issues pertinent to the clinical management of the client's psychiatric disorder may become apparent to the employment specialist in the process of working with the individual (e.g., medication side effects, disruptive or distressing symptoms), and communicating these problems to the treatment team may lead to effective solutions that both address the clinical problems and increase the client's ability to work. Third, clinicians involved in the treatment of the client's psychiatric disorder may have valuable suggestions for job leads or may recommend strategies for helping clients cope more effectively with persistent symptoms or cognitive difficulties. Fourth, clinicians may be help address problems that interfere with work, such as poor coping with symptoms and relapses, substance abuse, and limited interpersonal skills by providing these treatments directly or referring clients to appropriate services. For example, teaching illness self-management skills (Gingerich and Mueser 2010), cognitive behavioral therapy for psychosis (Morrison et al. 2004), integrated treatment for co-occurring substance use disorders (Mueser et al. 2003), and social skills training (Bellack et al. 2004) are evidence-based practices that can be effective at addressing these problems.

The integration of vocational and clinical services occurs most effectively when the employment specialist serves as a member of the client's clinical treatment team. In the absence of working as a formal member of the client's treatment team, a minimum of weekly contact between the employment specialist and clinical treatment providers is optimal for effective integration. The evidence strongly supports the vital role of this integration for better outcomes (Cook et al. 2005a, b).

Benefits Counseling

People with SMI have often suffered an arduous process of applying for and obtaining disability benefits. After this struggle to obtain benefits, it

is understandable that many clients are concerned about the effects of work on their benefits (MacDonald-Wilson et al. 2003). Benefits counseling is aimed at helping clients understand the impact of returning to work on their benefits, including how much they can work before experiencing a reduction in their financial benefits and the potential loss of their health insurance. In addition, benefits counseling also focuses on educating clients about different incentive programs for people with disabilities returning to work. There is good evidence that clients with psychiatric disabilities who receive personalized counseling on the impact of earnings on their benefits accrue more earnings from employment (Tremblay et al. 2006).

Client Preferences

Respect for individual client preferences is an important defining characteristic of supported employment. Client preferences for the type of work desired can inform the job search. Research shows that clients who obtain jobs that match their prevocational areas of interest have significantly longer job tenures than clients who obtain jobs outside of their areas of interest (Becker et al. 1996; Mueser et al. 2001a). Client preferences also have a significant bearing on the type of supports provided by the employment specialist. Some clients are willing to disclose their psychiatric disability to a prospective employer, thereby enabling the employment specialist to play an active role in helping the person obtain the job and keep it through direct contacts with the employer. Other clients prefer not to disclose their psychiatric disability, in which case the employment specialist plays a "behind-the-scenes" role in helping the client achieve his or her employment goals.

Rapid Job Search

The process of helping clients find a job begins soon after the client joins the program, usually within 1 month. This is in contrast to other vocational approaches, which may require prevocational skills training and/or extensive workplace assessments that involve extensive periods of time to complete. Research suggests that when clients receiving prevocational preparation prior to beginning a job search often become habituated to prevocational settings and never seek competitive employment; they also lose interest and drop out of vocational services (Bond 2004). Therefore, rapid job search is one of the most defining characteristics of supported employment programs.

Follow-Along Supports

Historically, vocational rehabilitation was deemed successful when a client obtained competitive employment and remained in that job for a period of a few months, at which point funding for follow-along support was discontinued. In contrast, supported employment continues to provide follow-along supports after the individual has obtained a job. Furthermore, follow-along supports are not limited by specific time periods imposed on the client's participation in the program. A wide variety of follow-along supports may be provided, ranging from helping the client learn job-related tasks, to providing on-site or off-site support to the client, negotiating reasonable accommodations with an employer, to facilitating the transition to new job responsibilities or a new job. Provision of follow-along supports for a year or more after a client obtains a job is associated with longer job tenure (Bond and Kukla 2011).

Other Features of Supported Employment Programs

In addition to the principles described above that guide the provision of supported employment services, there are several key features of supported employment that distinguish this model from other approaches to vocational rehabilitation. Work is a normalizing activity that takes place in the community, and therefore most

supported employment services are provided in the community, rather than at the mental health center or vocational rehabilitation agency. Employment specialists meet with clients in settings that are convenient and comfortable for them, and often spend time together walking around the community, exploring possible jobs, and talking to prospective employers.

Supported employment is also recovery-oriented and strengths-based. In recent years, the "consumer movement" has argued successfully for a redefinition of recovery that is not based on the absence of psychopathology (as in traditional medical definitions), but rather defined in terms of individual consumers' hopes and dreams (Davidson 2003). Thus, recovery has been defined as "the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony 1993). Another definition of recovery is "the process in which people are able to live, work, learn, and participate fully in their communities" (President's New Freedom Commission on Mental Health 2003). As work is a common personal recovery goal for many clients (Provencher et al. 2002), the emphasis in supported employment on community-based services, competitive employment, zero eligibility exclusion criteria, and respect for client self-determination are all compatible with the philosophy of recovery.

Also consistent with recovery is the emphasis of supported employment on client strengths rather than deficits, and viewing the community as a potential resource rather than a barrier to the client's employment goals (Rapp and Goscha 2006). The identification of client strengths plays an important role in building up clients' self-confidence and helping them sell themselves to prospective employers. Employment specialists are always on the lookout to engage natural supports for the client in the community, including both at the workplace (e.g., supervisor, coworkers), at home (e.g., family or friends), as well as in the client's treatment team. Capitalizing on natural supports in the client's environment takes advantage of the spontaneous opportunities these individuals may have to help the client, often at times when the employment specialist cannot be available, thereby avoiding unnecessary dependence on the employment specialist for providing all the needed supports.

Although employment specialists provide a full range of vocational services, such as job development and follow-along supports, they often may be involved in helping clients manage their psychiatric disorder more effectively and improving their interpersonal skills. For example, cognitive difficulties may make it difficult for some clients to achieve their vocational goals (McGurk and Mueser 2004) and employment specialists are often actively involved in helping clients use coping strategies for managing or minimizing their cognitive difficulties (McGurk and Mueser 2006).

The Organization of Supported Employment Services

Supported employment programs are organized by a team structure that is staffed by at least one half-time director of the program, and two full-time employment specialists. The director of the program carries a reduced caseload of clients receiving supported employment services. The director provides weekly supervision to the employment specialists and serves as a liaison for the program or other teams and programs, both within the agency and at other agencies. Employment specialists work full-time providing vocational services, and do not have clinical responsibilities, such as case management, leading skills training groups, or providing psychotherapy. This requirement prevents employment specialists from having to make decisions about whether to provide vocational services or some other service to clients with whom they are working.

In addition, employment specialists provide a full range of supported employment services described above (e.g., assessments, job development, and provision of follow-along supports). This is in contrast to some vocational programs, in which services such as job development and follow-along supports are provided by different individuals. Having each employment specialist

provide the full range of vocational services has the advantage of not requiring the client to develop relationships with different vocational service providers as they progress from job seeking to obtaining to holding down a job. By having all employment specialists involved in job development rather than just one or two specialists a much broader range of jobs can be developed within a supported employment program. While job development is done on an individual client basis, jobs are often identified that may not be suitable for one client, but which can be shared with other employment specialists to the benefit of other clients in the program.

Research on the Effectiveness of Supported Employment

Numerous reviews conclude that supported employment is effective in helping clients achieve competitive employment (Bond 2004; Bond et al. 1997a, b, 2001a, b, 2008a, b; Burns et al. 2007; Crowther et al. 2000; Twamley et al. 2003). In this summary, we limit the focus to evaluations of high-fidelity IPS programs, because of the strong evidence suggesting that fidelity to IPS is associated with better employment outcomes (Bond et al. 2011). The literature on early studies of supported employment prior to the standardization provided by IPS yielded weaker but nonetheless significant findings supporting the same overall conclusions (Bond et al. 1997a, b).

Two lines of research supported the effectiveness of IPS: quasi-experimental studies examining conversion of day treatment services to IPS, and randomized controlled trials (RCTs) of well-implemented IPS programs. We also briefly summarize the findings from two long-term follow-up studies.

Day Treatment Conversion Studies

Three quasi-experimental studies evaluated the impact of day treatment programs converting their rehabilitation services to IPS. The initial study was a natural experiment comparing two rural mental health centers in neighboring communities. One center closed its day treatment program and replaced it with IPS; the other continued day treatment along with traditional brokered vocational services (Drake et al. 1994). The competitive employment rate increased substantially at the conversion site, while the rate was unchanged at the comparison site. Moreover, the conversion site had no increases in negative outcomes (e.g., hospitalization, incarceration, dropouts). Clients, their families, and mental health staff had favorable reactions to the conversion, though a minority identified loss of social contact as a drawback (Torrey et al. 1995). Interestingly, many clients who did *not* find work also reported that they benefited from the change because they developed valued activities *outside* the community mental health center. The findings from replication studies have been similar; the employment rate for all former day treatment clients, including those not interested in working, nearly tripled after conversion, increasing from 13 to 38%, while the employment rate for control sites remained static (12% pre vs. 15% post) (Bond 2004).

Randomized Controlled Trials

The most recent comprehensive review of IPS identified 11 RCTs with 811 IPS clients and 876 control clients (Bond et al. 2008a, b). The control conditions were varied, but typical were either referral to the state vocational rehabilitation system or equivalent or assignment to an alternative vocational model. In most studies, participants were clients receiving services from community mental health centers. In all the studies, participants were unemployed at the time of study admission. The mean length of follow-up was 18 months.

All 11 RCTs included multiple measures of competitive employment outcome. The one universally reported competitive employment outcome was the *competitive employment rate*, defined as working a competitive job at any time during follow-up.

In all 11 studies, the competitive employment rate was significantly higher for the IPS condition

than for controls. In total, 476 (58.7%) of IPS participants obtained employment, compared with 202 (23.1%) control participants. Averaging the rates across studies, the cumulative competitive employment rate was 61% (Median = 64%) for IPS compared to 23% (Median = 27%) for controls. The mean difference in percentage employed between IPS and controls was 38%, ranging from 20 to 55%.

Long-Term Outcome Studies

Most IPS evaluations described above have had follow-up periods of 2 years or less. However, two long-term interview studies of IPS participants have been completed. In a 10-year follow-up study, 86% worked during follow-up and 33% were "steady workers" (employed at least 50% of the follow-up period) (Salyers et al. 2004). In a second study, 100% had worked during follow-up 8–12 years after enrollment and 71% were steady workers (Becker et al. 2007). Other studies also suggest durable long-term outcomes from supported employment (Bond et al. 1995a, b; McHugo et al. 1998; Test 1992).

The implications of this research are especially significant in light of two general findings. First, as noted earlier, the competitive employment rate for individuals with SMI in the public mental health system is 15% or less. Therefore, a steady employment rate of 50% or more in this population is far above the norm. Second, these findings are in stark contrast to the attenuation effects found for many psychosocial interventions once the active intervention has been discontinued (e.g., Stein and Test 1980). Once IPS clients begin working, the natural reinforcers of the workplace (a paycheck, making a meaningful contribution to society, social connectedness) may provide incentives to continuing to work. In any case, the "yo-yo effect" of diminishing gains following treatment cessation for weight loss and exercise programs has not been found for IPS. These findings suggest that IPS promotes a life trajectory that differs from that of patienthood and dependence.

Dissemination of Supported Employment

The simplicity and clarity of the IPS model of supported employment has facilitated the development of a standardized fidelity scale, which has proven to be associated with better competitive employment outcomes in 9 of 10 multisite studies examining its predictive validity (Bond et al. 2011). This fidelity scale has in turn been the lynchpin of dissemination efforts nationally and internationally.

The National Implementing EBP Project examined strategies and barriers to implementing 5 EBPs, including supported employment, in 55 community mental health centers in 8 states (McHugo et al. 2007). Among 9 sites implementing supported employment, 8 (89%) reached high fidelity within the first year and maintained high fidelity at 2-year follow-up (Bond et al. 2008a, b). IPS had greater success in implementation than the other four EBPs. At the 4-year follow-up, 78% of the supported employment programs were still in operation (Swain et al. 2009).

Other large-scale supported employment dissemination projects have also reported positive results (Frey et al. in preparation; Becker et al. 2011; Drake et al. 2006). Major initiatives outside the USA have reported encouraging progress in implementing supported employment (Menear et al. 2011; Boyce et al. 2008; Rinaldi and Perkins 2007; van Erp et al. 2007; Waghorn et al. 2007). In summary, widespread implementation of IPS with high fidelity is attainable when there are committed state and local leadership, adequate resources, skilled supervisors, and knowledgeable and skilled staff.

Costs of Supported Employment

Several studies have estimated an average annual cost of supported employment of approximately $5,000 per client in 2010 US dollars (Latimer et al. 2004; Salkever 2010). Although the definitive long-term costs studies have not been completed, there is evidence that the cost of supported

employment may be offset by the cost reductions in mental health treatment for clients who obtain steady employment (Bond et al. 1995a, b; Clark 1998; Latimer 2001; Perkins et al. 2005; Schneider et al. 2009). Several studies have found a reduction in psychiatric hospitalization days and emergency room usage after enrollment in supported employment (Burns et al. 2009; Henry et al. 2004; Rogers et al. 1995). Service agencies that have replaced their day treatment programs with IPS have reduced service costs by 29% (Clark 1998). A promising area for cost savings concerns young adults who are experiencing early psychosis. If supported employment were universally accessible in the USA, an economic model has projected annual savings of $368 million in Medicaid, Social Security and other federal and state programs, primarily through averting entry of new applicants to the federal disability programs (Drake et al. 2009).

Conclusions and Future Directions

Abundant research shows that the IPS model of supported employment is effective at improving employment outcomes in persons with SMI. In addition to the clinical efficacy of the IPS model, research has demonstrated that the program can be implemented and sustained in routine community settings. Furthermore, economic analyses suggest that only a modest cost is required to implement supported employment and that these costs may be potentially offset by decreases in the use of other mental health services.

The success of the IPS model has led to several other avenues of research, including trying to identify ancillary services designed to target client characteristics thought to interfere with achieving positive vocational outcomes. These include supplementary social skills training (Mueser et al. 2005; Wallace and Tauber 2004; Wallace et al. 1999); and cognitive remediation for those with impaired cognitive functioning (Wykes et al. 2011; Bell et al. 2005; Lindenmayer et al. 2008; McGurk et al. 2009; Vauth et al. 2005). Another important area of research on supported employment concerns its impact on people with a first episode of psychosis (Killackey et al. 2008; Nuechterlein et al. 2008). More work is needed to address the impact of supported employment in this population, and to establish standardized guidelines for providing supported education.

The rehabilitation field has made important strides in improving employment outcomes for people with SMI over the past two decades. The IPS model of supported employment is an evidence-based practice for vocational rehabilitation. An important priority is to increase the access of persons with SMI to supported employment programs, which have the potential to enhance quality of life by improving the economic standing of clients, giving them something meaningful and rewarding to do with their time, and promoting their integration into their communities.

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26 Behavioral and Physical Health Self-Management

Anthony J. Salerno and Paul J. Margolies

Introduction

In addition to its traditional focus on acute illnesses and injuries, our healthcare system has increasingly focused on enduring, serious conditions (Wagner et al. 2001). With this shift in focus has come a shift in the role for users of these services. For acute problems, there is little need to engage patients in having the knowledge and skills to successfully self-manage persisting conditions. This changes considerably when the focus shifts to enduring conditions. The term chronic is customarily used in the medical community to describe enduring conditions, while the behavioral health system typically refers to serious and persisting conditions. Both terms are used throughout this chapter to describe those nonacute conditions that are long lasting, associated with functional difficulties, and require ongoing care.

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The concept of health self-management has been employed widely in the treatment of chronic physical health problems (Lorig et al. 1993; Anderson et al. 1995; Boulware et al. 2001) and has been increasingly applied in behavioral healthcare as well (Copeland 1997; Salerno et al. 2007). It refers to the important role that patients must play in the management of their mental health, substance use, and related physical health problems.[1]

For adults with serious mental health and/or substance use problems, *behavioral and physical health self-management* refers to the integration of recovery principles with interventions that enhance an individual's ability to self-manage behavioral and physical health problems. This term is meant to emphasize the importance of an active and involved patient in managing enduring health problems and also recognizes the interdependence of behavioral and physical health issues. Each influences and is influenced by the other.

The purpose of this chapter is to describe:

- A conceptual framework for self-management approaches
- Key dimensions of effective self-management approaches
- Self-management behavioral health programs in use today
- Implications for the role of psychiatrists and other healthcare providers

[1] Throughout this chapter, we will use the term behavioral health to cover both mental health and substance abuse.

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Conceptual Framework

The successful management of healthcare conditions, including behavioral health problems, is inextricably linked to the patient's degree of involvement and personal responsibility (Ouwens et al. 2005; Bauer et al. 2006). The newest treatments provided by knowledgeable and skillful practitioner are ineffectual without the day-to-day efforts of actively involved patients.

All too often, healthcare providers engage patients in managing their healthcare problems with easy but low impact strategies such as verbal instructions to follow treatment recommendations, report problems, and live a healthier lifestyle. Such instructions may be supplemented with informational handouts or brochures. Experience has shown that this is not enough. The ongoing management of behavioral and/or physical health problems requires a significantly greater degree of support from providers.

Increasingly, practitioners are likely to encounter individuals with co-occurring problems that include mental health, substance use, and related physical health difficulties (Drake et al. 2001; Parks et al. 2006). These three domains are often interdependent and multidirectional. Assisting patients to increase their self-management capabilities in all three areas is increasingly the challenge for behavioral healthcare practitioners and systems.

Many forms of treatment for behavioral and related physical health problems include self-management strategies such as problem solving, practical skills training, effective coping, stress management, relapse prevention, and education about symptoms, diagnosis, causes, and treatment options. Unfortunately, these strategies are often provided as separate and uncoordinated interventions rather than aspects of a comprehensive behavioral self-management plan.

The movement in recent years to improve healthcare outcomes for individuals with serious behavioral and/or physical health problems has led to a need to develop integrated, coordinated, and person-centered medical homes (American College of Physicians 2005; Sia et al. 2004). In this model, one key goal is to engage consumers and members of their support network to use information, tools, and community resources to enhance self-management activities.

The concept of *behavioral and physical health self-management* may serve as a useful organizing framework that integrates the variety of interventions that share the common purpose of activating and strengthening the individual's role in personal health management.

Four important concepts that guide thinking in this area are:

- Chronic care model (CCM) (Wagner 1998)
- Shared decision making (Charles et al. 1997; Deegan and Drake 2006)
- Theory of planned behavior (Ajzen 1991)
- Self-efficacy (Bandura 1982)

Chronic Care Model

The CCM (Wagner et al. 1996; Wagner 1998; Bodenheimer et al. 2002a, b) is a multifaceted and system-minded approach to achieve quality in health. According to the CCM, one critical element of a quality healthcare system is support for self-management. The CCM model emphasizes the importance of collaboration among the care team members—including the patient and social supports such as family and friends—all of whom play a role in promoting successful management of chronic conditions. One of the key functions of the care provider is to assist patients to obtain information that supports informed decision making, learning practical coping strategies, and using treatment and social supports to self-manage healthcare problems. As noted by Wagner et al. (2001) "medical care must assure that persons with chronic illness have the confidence and skills to manage their condition."

Consistent with the CCM are efforts to address the physical health crisis among people with serious mental health and/or substance use problems (Parks et al. 2006). This has led to nationwide calls to action to redesign systems of care that enhance access, coordination, collaboration, and integration of behavioral health and primary care. This cannot be done without patients self-managing significant aspects of persisting health problems.

One notable example that is consistent with the CCM is the IMPACT approach, which helps primary care providers identify and treat individuals with depression in a manner that focuses on strengthening self-management knowledge and skills (Vannoy et al. 2006).

Shared Decision Making

There is a growing literature on shared decision making in medical (Charles et al. 1997; Elwyn et al. 2000) and behavioral healthcare (Deegan and Drake 2006; Adams et al. 2007). Also see Chap. 30 (diamond).

Charles et al. (1997) note that key characteristics are (1) that at least two participants—physician and patient—be involved; (2) that both parties share information; (3) that both parties take steps to build a consensus about the preferred treatment; and (4) that an agreement is reached on the treatment to implement. Elwyn et al. (2000) identify key clinical and interpersonal skills required by the practitioner: (1) implicit or explicit involvement of patients in the decision-making process; (2) explore ideas, fears, and expectations of the problem and possible treatments; (3) portrayal of equipoise and options; (4) identify preferred data format and provide tailor-made information; (5) checking process: understanding of information and reactions (e.g., ideas, fears, and expectations of possible options); (6) acceptance of process and decision-making role preference; (7) make, discuss, or defer decisions; (8) arrange follow-up.

Within behavioral healthcare, Deegan and Drake (2006) argue that shared decision making is a partnership between two experts—the client and the practitioner—that aims to work through decisional conflicts rather than impose adherence to treatment decisions in which the client was uninvolved.

Theory of Planned Behavior, and Self-Efficacy

The theory of planned behavior posits that one's intention to behave in a certain way is based on (1) one's positive beliefs about the consequences of that behavior (2) whether that behavior will be positively supported by people who matter to the person, and (3) whether the person has confidence and control over the behavior. This last point is closely aligned with the concept of self-efficacy (Bandura 1982) which maintains that a person's effortful coping and determination to work towards important outcomes is linked to one's confidence in having the knowledge, skills, physical ability, and resources to attain specific goals. When taken together, these important concepts inform us that self-management approaches must go beyond the imparting of basic information and practical facts about specific health conditions. These approaches should include opportunities for patients to discuss the relative valence of self-management-related behaviors and the support available for these efforts. Self-management approaches should be designed to enhance confidence and personal control over important decisions. Providers need knowledge and skills to support patients' self-management and values that place a priority on this process.

Key Dimensions

What does a person with a persisting behavioral health and/or related physical problems need to manage? What knowledge, skills, resources, or supports does a person need in order to manage his/her day-to-day challenges over time, and across situations and environments? Lorig and Holman (2003) present a model for the management of persisting physical healthcare conditions that can inform similar work in behavioral healthcare. Their work with the Stanford Patient Education Research Center (http://patienteducation.stanford.edu/programs/) has included numerous in-person and online self-management educational programs to address a wide variety of medical healthcare conditions such as diabetes, arthritis, and chronic pain. More recently, the Stanford Center has been expanding their approach to address psychological problems such as posttraumatic stress disorder, dementia, and traumatic brain injury.

In their self-management model, individuals with chronic healthcare problems need to manage three related challenges:

- The medical condition itself (i.e., active involvement in prescribed treatment and procedures designed to alleviate symptoms and to control adverse outcomes)
- The common emotional responses to serious healthcare problems (i.e., anxiety, depression, stress, disappointment, shame, and guilt)
- Lifestyle and role modifications needed to support and sustain improvements in managing one's health

Successful management of serious healthcare conditions requires the patient's active attention to all three challenges.

How is this accomplished? What knowledge and skills are needed? In Lorig and Holman's model, healthcare practitioners provide patient education and health promotion programs to assist individuals to acquire the knowledge, information, skills, and strategies needed to successfully manage the medical, emotional, and life role challenges.

They identify six core knowledge and skill areas needed by individuals to manage these challenges:

- Identifying, defining, and solving problems
- Making informed decisions
- Participating in a healthcare partnership with providers
- Knowing and using treatment and support resources
- Planning and taking action
- Self-tailoring in which the patient's readiness, preferences, skill level, support system are taken into account in deciding the most practical and personally acceptable actions to take

Self-Management Behavioral Health Programs in Use Today

Self-management programs in behavioral health have been, and continue to be, developed. They share the common goal of enhancing an individual's active participation in and responsibility for treatment outcomes and quality of life improvements. They involve imparting information and assisting participants to make informed decisions and to take action to increase self-management capabilities. These programs tend to differ on the range of issues covered, which aspects of self-management are emphasized, the specific methods and resources employed to engage patients, and logistical requirements.

The challenge is to develop resources, tools, and practical approaches that support behavioral healthcare practitioners, provider organizations and clients to achieve successful treatment, rehabilitation, and recovery outcomes. Many of the behavioral self-management resources that have been developed in recent years address a number of the dimensions described by Lorig and Holman. These include: Wellness Recovery Action Plans (WRAP) (Copeland 1997), Neuroscience Treatment Team Partners (NTTP) (Vreeland et al. 2006), Illness Management and Recovery (IMR) (Mueser et al. 2002), and Wellness Self-Management (WSM) (Salerno et al. 2007).

There are similarities and differences among these four resources. Each has been designed for adults with serious mental health problems that can be used in individual sessions and group meetings. WRAP, IMR, and WSM offer patients the opportunity to develop personalized plans for maintaining wellness and addressing early warning signs as they appear. IMR and WSM address substance use as well as mental health issues. NTTP and WSM also address the importance of a physically healthy lifestyle in the management of mental health and substance use problems.

Wellness Recovery Action Planning

Mary Ellen Copeland designed WRAP plans to help individuals diagnosed with mental illness to take an active role in maintaining personal mental health wellness. Goals include decreasing/preventing symptoms, increasing personal empowerment, improving quality of life, and helping the individual to achieve personal goals. The individual works with trained peers to develop a detailed wellness plan. Elements of the plan include maintaining daily wellness, identifying

and dealing with triggers, identifying and dealing with early warning signs, identifying when things are breaking down and what to do, and developing detailed crisis plans. In a recent study (Cook et al. 2009), significant improvements in self-reported symptoms, recovery, hopefulness, self-advocacy, and physical health were noted.

Further information about WRAP can be found at http://www.mentalhealthrecovery.com/.

Neuro Treatment Team Partners

The NTTP approach to self-management was developed at the University of Medicine and Dentistry of New Jersey. Sponsored by Lilly, the NNTP offers free self-management informational materials in mental health (Team Solutions) and physical health (Solutions for Wellness). NTTP uses the ten components of Recovery as identified by Substance Abuse and Mental Health Services Administration (SAMHSA) in December of 2004. Team Solutions focuses on mental health and wellness and provides ten workbooks focusing on such topics as partnering with your treatment team, understanding your illness, and understanding your treatment and managing crisis. Solutions for Wellness focuses on physical health and wellness and guides patients to make informed healthy lifestyle decisions. Its two workbooks focus on healthy lifestyle choices related to nutrition, exercise, and stress management and offer approximately 50 hours of psycho educational materials. Furthermore, Solutions for Wellness has also been designed as a self-directed online program that assists individuals to improve physical health in ways that support mental health. These materials include both practitioner guides and informational handouts that address both mental health and physical health issues. Further information about NTTP can be found at http://www.treatmentteam.com/Pages/aboutNeuroscience.aspx.

Illness Management and Recovery

IMR is recognized by SAMHSA as an evidence-based practice and was one focus of SAMHSA's national Evidence-Based Practices dissemination project in 2002–2005 (McHugo et al. 2007). It is a curriculum-based treatment that utilizes research-informed psychosocial approaches. It empowers patients to manage their illnesses, develop their own goals for recovery, and make informed decisions about their treatment. Topics include: Recovery strategies, Practical facts on mental illness, Stress vulnerability model and treatment strategies, Building social support, Using medication effectively, Drug and alcohol use, Reducing relapses, Coping with stress, Coping with problems and persistent symptoms, and Getting your needs met in the mental health system.

Interventions provided by practitioners include psycho education, behavioral tailoring of medication, coping skills training, and relapse prevention.

The IMR resource kit includes promotional materials for a variety of stakeholders, informational handouts for consumers, and a comprehensive practitioner's manual. IMR can be employed in individual and group meetings. Its intervention components have been found to contribute to positive symptom and functional outcomes (Mueser et al. 2002). Recently, the effectiveness of the IMR package has been examined, with positive effects found on hospitalization rates, symptoms, hopefulness, and psychosocial functioning (Salyers et al. 2010; Levitt et al. 2009; Mueser et al. 2006). Further information about IMR can be found at www.samhsa.gov/SHIN.

Wellness Self-Management

WSM is an adaptation of the IMR practice developed by the New York State Office of Mental Health. In WSM, the entire curriculum, consisting of 57 lessons, is organized into a bound workbook that belongs to the participants. The workbook was designed to emphasize and reinforce the principles of recovery such as shared decision making, choice, and hope; recognize the role of cultural beliefs and values; highlight the connection between mental and physical health; and address the challenges of providing WSM services in a group modality.

The topics covered in the WSM program are designed to provide participants with the knowledge and skills that promote informed decision making and self-management competency. In accordance with the key issues proposed by Lorig and Holman, the WSM curriculum helps participants identify and solve problems, form effective healthcare partnerships, use treatment services effectively, plan, and take action steps in support of health and select health-promoting actions based on personally meaningful and culturally respectful values.

The WSM program is most often delivered in a group format, although it can be utilized in individual treatment as well. WSM sessions are held a minimum of once weekly and variations including back-to-back sessions and multiple sessions per week have been reported. While duration of the WSM program varies, it typically takes a year or more to complete the entire curriculum. Programs with shorter lengths of stay such as inpatient hospitals select specific lessons that most closely match the needs of patients at that time

Optimally, WSM groups are closed groups in order to provide members with a secure environment in which they can build a sense of trust and camaraderie. However, when this is not possible, WSM programs have been successfully conducted in open groups. The use of the workbook facilitates the entry of individuals at various points throughout the program. Each group ideally consists of 8–10 members and is led by two group facilitators. Peer-facilitation is strongly encouraged. WSM also assists individuals to consider involving family and friends who may be able to support their work by assisting with action steps, giving encouragement, providing needed information, and discussing topics of interest.

WSM has been successfully implemented in over 120 agencies involving over 5,000 consumers across numerous program types, clinical conditions, and cultural populations. Participants report substantial gains in accomplishing personally meaningful goals which are substantiated by their treating clinicians (Salerno et al. 2011). The workbook is currently available in English, Spanish, Korean, and Chinese.

Adaptations to the original WSM workbook include Wellness Self-Management Plus (WSM+) (Salerno et al. 2008) designed for individuals with co-occurring mental health and substance use problems and the Knowledge Empowers You (KEY) workbook, (Salerno et al. 2009) designed to address the self-management needs of adolescents with mental health concerns.

Further information about WSM can be found at http://www.practiceinnovations.org/WellnessSelfManagementWSM/tabid/118/Default.aspx.

Implications for the Role of Psychiatrists and Other Healthcare Providers

As noted previously, *behavioral and physical health self-management* is built on a conceptual foundation based on the CCM, shared decision making, and theories of planned behavior and self-efficacy. Each of these informs the role of psychiatrists and other healthcare providers.

The CCM reminds us that this work can occur only with an active patient and an encouraging provider. The active patient needs knowledge and skills to take personal responsibility for maintaining wellness and needs to work with providers who are capable of teaching these skills. Providers need to believe that this is possible and will lead to positive outcomes.

As noted previously, Elwyn et al. (2000) identify eight key clinical and interpersonal skills required by the practitioner for shared decision making. They emphasize the value of providers being knowledgeable and skillful about developing and maintaining active partnerships with patients and needing to believe that such partnerships are possible and positive.

Theories of planned behavior and self-efficacy tell us that the patient needs to believe that her/his empowered role is possible and will lead to positive outcomes. Providers need to believe this as well.

The implications for training of psychiatrists and other providers are clear. It will be important that training efforts:

- Emphasize the value of true partnership with patients.

- Emphasize the importance of the relationship with the patient—one that is person-centered and curious about the patient's values, concerns, worries, and goals.
- Provide knowledge about shared decision making and related patient-activating methods.
- Teach the skills necessary for the provider to competently work with patients in this manner. These include engagement, listening skills, assessment of strengths, cultural competency, problem solving, and use of decisional balance tools.

Finally, it is important to recognize that emerging models of healthcare delivery emphasize the importance of integrated services provided by a health services team that includes multidisciplinary professionals as well as peers. Increasingly, peers who have made progress in their recovery and have enhanced their self-management skills will play a key role in helping others and being an integral part of the treatment team (Davidson et al. 2006). Peers will contribute uniquely as healthcare self-management coaches. Consequently, community psychiatrists will increasingly find themselves working with other healthcare providers in a collaborative and coordinated fashion in which all members play a key role in the consumers care.

Conclusions

As increasing numbers of healthcare and behavioral healthcare patients present with chronic, enduring problems, increasing importance has been placed on the active role of these patients in their own care. This has led to a greater emphasis on behavioral and physical self-management approaches.

In behavioral health care, a number of self-management approaches have emerged in recent years: WRAP, NTTP, IMR, and WSM are highlighted in this chapter. One thing that these approaches have in common is an emphasis on an engaged, active patient who takes responsibility for maintaining her/his personal wellness by working with personal supports including healthcare providers.

Although the self-management programs described in this chapter are designed for adults with serious behavioral and physical health problems, the concept of self-management is likely to be a useful conceptual framework to address the needs of all clinical populations who are struggling with persisting emotional, cognitive and/or behavioral difficulties.

It is important to recognize that informational and educational resources and tools may be helpful, but are likely to be insufficient in achieving successful outcomes (Elwyn et al. 2000). The patient–practitioner partnership is essential, even when discussing self-management. Self-management, as an approach to the treatment of persisting behavioral and physical health problems, takes place in the context of an interpersonal process characterized by mutual respect, trust, and shared responsibility. Partnership building is more than simply another skill area, but the foundation of an ongoing healing relationship.

In recent years, and especially with the advent of the internet, educational resources designed to inform individuals about behavioral and physical health problems and associated treatments have proliferated. Increasingly, online tools that are self-managed without professional guidance are becoming more popular. Lorig and Holman (2003) note:

> To make programs acceptable to patients, choices are needed: small-group self-management programs, group visits with providers, internet-mediated programs, telephone counseling, and automated telephone disease management have all demonstrated effectiveness.

As self-management programs are developed and implemented, it will be important to insure that they meet the prevailing standards of *medical necessity* as defined by insurance companies and the Centers for Medicare and Medicaid Services. Employing curriculum-assisted approaches enables the practitioner to specify the content, structure, and processes of the intervention. Such specificity is helpful in demonstrating medical necessity. The curriculum should be focused on the behavioral health problems that require treatment. Rehabilitation services designed to increase a person's functioning by increasing knowledge and skills to self-manage stress, symptoms, lifestyle changes, social and emotional difficulties are also likely to meet the standards of medical necessity. The key is to

assess problems requiring treatment and rehabilitation and to develop a clear treatment plan with methods, timeframes, and expected outcomes.

It is clear that in medical and behavioral healthcare, this is the era of self-management. This chapter has introduced a number of treatment programs that are currently available, helping patients to take responsibility for, and gain control over, their person wellness. No doubt, new innovative programs and methods will develop over the course of the next years and decades. What is not likely to change, however, is a system of care for enduring illness that relies as heavily on the patient as it does on the provider.

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27 Psychopharmacology and Medication Adherence

Ron Diamond

Collaboration, Shared Decision-Making, and Using Medication to Support Recovery

Medication is an important part of the treatment of people with serious mental illness. People with schizophrenia and bipolar disorder will have a more stable life, fewer relapses, and fewer hospitalizations if they consistently take appropriate medication (Gilmer et al. 2004; Lang et al. 2010). Despite its demonstrated effectiveness, many people with serious mental illness either refuse to take prescribed psychiatric medication or take it inconsistently (Fenton et al. 1997; Lacro et al. 2002; Velligan et al. 2010). Often, medication is considered not only important, but the critical element of treatment, especially for people with schizophrenia and bipolar disorder.

Inconsistent medication use is an issue not just with mental illness, but with all chronic illness. People with high blood pressure, diabetes, and other chronic illnesses also tend to be inconsistent with medication, despite clear benefit from following treatment recommendations (Yang et al. 2009; Mann et al. 2010). The issue is perceived as different for people with mental illness. Often there is an assumption that medication nonadherence is connected to impaired judgment that is part of the underlying illness (Cramer and Rosenheck 1998). Clinicians see their task as "convincing" a person to take prescribed medication, and attempting to use coercion when medication is refused. The common approach is to overcome the patient's irrationality through exhortation about the benefit of medication, close supervision of medication use, or forcing the use of medication.

A person is labeled "treatment resistant," even if they are willing to accept all other parts of a recommended treatment except for the medication. Unfortunately this attitude can lead to an adversarial relationship between clinician and consumer, focused more on medication compliance than on other important life issues. This chapter suggests an alternative view of medication that can serve to reframe the problem and potentially lead to different kinds of solutions. The issue is not "compliance" or "adherence," but how medication can be used as effectively as possible in helping the person deal with some of the problems caused by the illness. The key strategy is to work with the consumer to develop areas of common understanding of a problem, and the potential role of medication in helping to decrease the distress caused by this problem. There is no need to agree about everything. Effective treatment only requires that there are some areas of agreement that can be addressed collaboratively by both consumer and clinician (Diamond and Scheifler 2007). The focus is not on "medication

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compliance," but rather on the person's own goals, hopes, and beliefs about the problem and the solution. The most important clinical issue is not whether the person is taking medication as prescribed; it is whether the person's life is getting better in ways that are important to him or her, and whether medication is being used as effectively as possible to support this improvement.

Medication Is More Likely to Be Used When Both Client and Clinician Can Agree on the Nature of the Problem, and Agree That This Problem Could Be Responsive to Medication

Medication is a tool. As with any tool, it can help with some problems and not with others. It is not "good" or "bad." Rather it is either effective or ineffective. The goal of treatment is not to get a person to take prescribed medication; the goal of treatment is to help the person have a better life. Before we decide to use a tool, we have to understand what problem we want the tool to fix. An agreement on the problem is the first step to getting an agreement on the solution (Deegan 2005). This is more complicated than it might initially seem. The clinician may feel that frequent rehospitalizations or intrusive auditory hallucinations are the problem. The client may be more concerned about getting his own apartment or getting his driver's license back, and less concerned about the voices or going back to the hospital.

What Is the Problem That the Medication Is Supposed to "Fix?" Or Help with?

A *clinician's problem list* for a person with a psychotic disorder might include (1) hearing voices, (2) having a delusional belief that a large amount of money has been stolen, leading to frequent calls to police and complaints that frighten neighbors, and (3) having a delusional belief that people on the street are plotting about him, talking about him, following him, and making him too afraid to leave his apartment. Antipsychotic medication would be seen as a reasonable tool to help with all three of these problems. It seems clear that these significant problems are all symptoms of an illness. Antipsychotic medication is useful in the treatment of this illness. Once one has this perspective in mind, the need for medication becomes obvious and a refusal to use medication is a sign of irrationality. Unfortunately, the patient's problem list might look very different.

The client's problem list might include (1) I want to get back to school, but I cannot concentrate enough to read my math books. I don't really mind the voices all that much, but they are distracting and make it even more difficult to concentrate. (2) A large amount of money has been stolen from my apartment and no one believes me. When I call the police, they just laugh at me. The more I try to convince people, the more they just think I am crazy. (3) I am very afraid I am being set up to be murdered. I am not sure who or why, but always feeling afraid is terrible. (4) People talk outside of my window or seem to follow me when I go out. I realize that they are probably not always talking about me, but I am so scared that I cannot always figure out when they are talking about me and when it is just people talking.

The role of medication with this problem list is much less obvious. The voices themselves are not that big of a problem, medication is not going to help get his stolen money back or even get people to believe him, and he is not sure how medication will help him figure out when to be frightened and when not.

The clinician may feel that the medication has been very effective since the patient is less bothered by voices and is not going back to the hospital. The consumer may feel that the medication is useless, since even when taking the medication he still does not have enough concentration to do his school work, is still upset that no one believes him about the money being stolen, and is still concerned that he is being talked about and followed.

Medication is much more likely to be taken if it is helping in a way that the person taking it perceives is important, and will not be taken if it is not helping in ways that the patient feels is

important. If medication is a tool to help a problem, it will be used when both patient and clinician can agree on "target symptoms." Target symptoms are most useful if they are observable behaviors that both client and clinician can track.

A Consumer Is More Likely to Listen to and Seriously Consider a Clinician's Solution to a Problem, If the Clinician Is Willing to Listen and Seriously Consider the Consumer's Understanding and Solution to the Problem

Clinicians are often so convinced of their view of the problem that they dismiss the client's view as not worth serious consideration. Clinicians too often listen only enough to confirm a diagnosis. If I believe that something terrible has happened, I would be upset if no one believed me and still more upset if no one was willing to listen to me. If a friend told me about a catastrophe, I would be curious about the details, about when and what had occurred, who might have done what, or what else happened. I would not ask questions in an effort to disprove the event, but because I was interested in the details and in my friend's experience. This interest must be real. A fake interest is shallow and has an altogether different tone. Too often, when a consumer talks about something bad happening, it is treated very differently.

A real interest is not the same as passively waiting until the client gets finished telling about his or her delusions. A real interest does not require that we agree with all parts of what the consumer is saying, and certainly does not mean that we should pretend to agree when we do not. It does require that we suspend disbelief enough to seriously consider what the consumer is saying, rather than automatically discounting the complaint as a fabrication caused by mental illness. If we consider the client's account seriously, we develop a respectful curiosity about the details of the story that we may otherwise have dismissed.

This "serious curiosity" is the basis of cognitive behavioral therapy (Wright et al. 2009). The goal is to understand the details of the story, not to collect evidence to prove that the client is wrong. Details allow for the experience to be looked at in new ways by both clinician and consumer.

Ambivalence About Taking Medication Is the Norm, Not the Exception

Few of us actually like the idea of taking medication. We may like feeling better, and we may feel that the medication is necessary. We may have learned to put our ambivalence away so that we do not continuously think about the risks and side effects and the dependency on our medication. Still, ambivalence is the norm, not the exception. A typical clinical response to client ambivalence is to try to overwhelm it with rationality, reason, and exhortation. Sometimes this works, but most often it does not. If we try to "push" on one side of the dilemma, we can inadvertently strengthen the person's natural tendency to think about all of the arguments on the other side. Instead of convincing someone to do something we feel is important, we can incite the person to muster all of the arguments against this decision. Our push to get the client to make the "right decision" can sometimes strengthen the client's inclination to make the opposite decision.

As discussed in detail in Chap. 17, Motivational interviewing is an approach to behavioral change based on the idea that people are more likely to follow through with a decision if it is their own rather than someone else's (Miller and Rollnick 2002). Helping the client to develop his or her own argument about why something should be done will be a more powerful way to induce behavioral change than telling the client to make this same change. A client is likely to come up with a better decision if the clinician listens to him rather than argues with him. Once the client's concern has been fully addressed, then attention can be gently directed to the potential benefit of the medication. There is a place for direct support that the medication is needed and is working, but this direct support will be much more effective after the client has had a chance

to express his own concerns. Our issue is to guide the client into making those decisions that support his or her own life goals. It is the client's goals, and it is the client's behavior that must change to support those goals. Our job is to help the client develop his or her own argument to support behavioral change.

Client: I am very worried about getting tardive dyskinesia. You told me about this risk, and now I look at myself in the mirror and think I see the beginning of it.

Prescriber: What do you see when you look in the mirror

Client: I am not sure, but I think I see my face twitch some time. I am not sure I have it, but the idea of it scares me.

Prescriber: So the idea that you might develop tardive dyskinesia is pretty scary, even if there is not much evidence that there are signs of it now. Do you think the medication is doing any good?

Client: Well I am back in school and able to concentrate better, and I guess that is from the medication. I am also spending more time with friends, and less worried about people talking about me, and that could be from the meds.

Prescriber: So on the one hand, taking the medication and the possible side effect of tardive dyskinesia are pretty scary, and on the other hand the medication seems to have helped you get back to school, and has made it easier to spend time with friends.

Client: I think that I need to keep taking it, but it still scares me….

A Person Is More Likely to Take a Medication from Someone He Likes and Trusts, and Less Likely to Take a Medication Prescribed by Someone Who Is More Focused on the Medication Than on Him

We are all more likely to follow through with a suggestion made by someone we like and trust, and less likely if we distrust the motives of the person making the suggestion. Coming up with a diagnosis and writing a prescription is not enough. An effective physician must work to engender a trusting relationship. Many consumers have had the experience of feeling disrespected, not listened to, and not taken seriously. They bring this historical experience when they meet with new physicians. Many consumers are not at all clear if the physician is there "for them" or are there for some other more nebulous reason. Trust is something to be earned, and not assumed.

Medication Decisions Are Just That: Decisions. Dismissing a Consumer's Decision as "Just Part of the Illness" Interferes with the Development of a Dialogue and the Chance to Find Shared Understanding

Most of us would not take a medication just because we are told to do so by our physician. While we are influenced by our physician, we weigh the potential benefits of the medication and the potential risks and side effects and come up with our own decision. The same is true for people with mental illness. If the consumer agrees with the physician or is inherently compliant, then all goes well and the consumer takes the medication as prescribed, at least most of the time. At times, the consumer may weigh concerns differently than the prescriber, and decide to stop a medication or take it differently than prescribed. Most consumers have learned to avoid being too overt about their own views to avoid the inevitable pressure that would come if they openly disagreed.

It is important that the prescriber do everything possible to make the discussion about medication decisions overt rather than covert. The consumer must be encouraged to share his own views and decisions, and then not be punished for being honest. When I begin a dialogue with a patient, after asking about how his job is going or his painting or his goal of exercising, after I first focus on the person's own goals and hopes, I often ask how the medication is working and what he is taking. The answer is often a vague "it's going

OK." and this begins the conversation rather than ends it. A response that "I am taking medication almost all of the time" leads to a query about what happens when he misses some doses of meds, how long has he gone without taking it, and what has persuaded him to restart it. The tone is not an inquisition, but rather an open conversation and respectful curiosity about what decisions the consumer is making and the thinking behind these decisions. The issue is not to just persuade the person to take the medication more consistently. The goal is to understand the consumer's own ambivalence and thinking,. If one assumes every refusal is just lack of insight connected to illness, then it becomes impossible to have a conversation that leads to the sharing of ideas, and that allows us to learn from each other.

Taking Medication Always Has Meaning, for the Patient, for the Family, and for the Clinician

One person experiences medication as something that controls his life. Another experiences taking medication as something he can do to take more control over his own illness and his own life. One person sees medication as one more proof that he is damaged and disabled and not able to work. Another person sees medication as a tool that can help him overcome his illness and get back to work. The meaning of medication can change over time.

The meaning that always accompanies medication is not unique to mental illness. Survivors of breast cancer are often required to take medication that decreases the risk of recurrence, but comes with significant side effects. One person is reminded with every pill that the cancer may come back, while the self-talk for another person reinforces the message that taking medication is something she can actively do to prevent it from coming back.

Medication can increase, or decrease, the sense of personal power and control the person has over his own life. If I "medicate you," then I am doing something to you and your personal power will feel diminished. If medication is a tool that you can use in your own recovery, the same medication can work to increase your sense of control over your own life. Many people with serious mental illness are struggling with issues of control. A patient trying to assert control may connect taking medication with ceding power to others. Taking medication too often feels like a further loss of control and a further loss of personal power.

The prescriber can work to reinforce the idea that the consumer can use medication to take more control over his illness. For this to be effective, the locus of control must be with the consumer. The consumer has no real control if he is only allowed to make decisions that agree with those of the psychiatrist. At times, this means the consumer may make decisions that disagree with what others think would be best. The disagreement between consumer and clinician can be minor, such as taking a slightly lower dose of medication or choosing a different but similar medication, or major, such as discontinuing all medications. The psychiatrist and support people do not need to be neutral about these decisions and in fact they should not be. They should be clear about what they think is best. There also needs to be acknowledgment of the consumer's right to disagree with clinician decisions.

In the presence of mental health commitment and legal coercion, finding areas of collaboration becomes much more complicated. Even when there is a court order covering the use of medication, the goal is to support the consumer's own decisions as much as possible. It may matter less if a person takes 4 or 5 mg of risperidone, or thiothixene instead of olanzapine, than the consumer feeling some legitimate say in his or her own treatment even in the face of court order (Diamond 2008).

Medication also has meaning for other people in the consumer's life. Taking medication can be perceived as a sign of illness and damage, or a sign of the person becoming well. Family and even clinical staff often have unrealistic expectations of what medication could do if only the person would take it. Clinicians often feel the need to "do something" in the face of increasing distress. This translates into increasing the dose

of medication or adding a new one, even if this is more likely to increase side effects than increase efficacy.

Medication Decisions Are, in Part, Socially Mediated

Many of our decisions are strongly influenced by the views of our family and friends. What we choose to eat, what clothes we buy, and even whether we exercise or sit on a couch are all strongly influenced by those around us. It is not surprising that our decision to take or not take medication is similarly influenced. I am much less likely to take a medication if my friends feel this is a bad decision. There is often an assumption that only the direct consumer is involved in the decisions about what medications should be used. In reality there is a hoard of other people metaphorically in the room when the medication decision is being made and when the consumer decides whether or not to actually take the medication.

Even mass media play a part. If attractive, functional people are portrayed as using medication, we are more likely to be willing to take medication ourselves. If the only people taking psychiatric medication that we read about in magazines or see on TV are severely dysfunctional, then we get the message that we do not want to be doing what they are doing, we do not want our life to be like their life, and we certainly do not want to be taking psychiatric medication. We can get the message that medication is for "winners," or only for "losers," and this becomes part of our own conscious or unconscious decision-making process.

It can be useful, with the consumer's permission, to invite support people into the medication appointment. This includes family and friends who are supportive of the use of medication, and also those most opposed. The close friend or brother who is opposed to the consumer's use of medication will exert this influence whether or not they are included in the medication appointment. By including him, his concerns can be heard and perhaps addressed. Even if his views do not change, the consumer may be in a better position to balance the contrasting views of the people who support the use of a particular medication and those who are concerned about such use. Speakerphones and Skype can be used to include support people.

Side Effects Are Real. Decreasing Side Effects Can Make It More Likely That a Person Will Continue Taking Medication

We ask consumers to take medication that causes side effects that we would have great trouble tolerating. A minor side effect to the clinician may be perceived as a major life obstacle by the consumer. We ask consumers to tolerate weight gain that we would find very upsetting, or drooling that would cause us to stop an offending medication. We may not hear the distress caused by "minor" askathisia. We need to think about how we would react if we were experiencing the side effect reported by our consumers. How upset would we be, and what would we want done? Sharing information and decision-making with the consumer can be an effective way of trying to address these problems.

Often the right course of action is not clear. Is weight gain more important than sexual side effects? Is maximum efficacy more important than some increase in long-term risk? Many of these are value decisions rather than medical decisions. Is it worth the risk of trying a new medication, or better to stay on a medication that is working but causing significant weight gain? We need to help decrease side effects as much as possible. Just as important, we need to involve the consumer in decisions so that together we come up with solutions that make sense for him. The decisions may not always work out, but that is true for many medication trials and many medical decisions. Some decisions are more risky than others, and some may have more chance of working than others. This does not mean that the prescriber must go along with every request made by the consumer. Some requests and some decisions lie outside of medical prudence. I may not agree to prescribe high-dose diazepam for someone

who I know abuses alcohol. The goal is to strive for a set of decisions that are acceptable to both prescriber and consumer, even if both may feel that it is not what they would ideally choose.

Organization and Structure Can Help. It Is Important to Simplify the Medication Regimen, Help Connect Medication Taking to Other Structured Activity, Build in Reminders to Take Medication, and Consider Using Pillboxes or Special Packaging

Make those changes that can help a person take medication more consistently. Be interested in the consumer's actual medication use, and ask about barriers that make taking medication more difficult. Most psychiatric medications can be taken once a day, even if the package insert suggests twice a day. Consumers may benefit from assistance that connects taking medication with some other consistent life activity. We do this so automatically in our own life that we may not realize that a consumer may need some concrete help to come up with these strategies. Does the person regularly brush their teeth, or eat breakfast, or have a morning cup of coffee, or have a nighttime pattern before going to bed. Some compromises on "ideal treatment" may improve actual outcome. I personally take medication that should ideally be taken in the morning, but my mornings are rushed and chaotic and I have found that I take my own medication more consistently if I take it before bed. Ideal management of diabetes often requires a complicated regimen of different medications at different times of day. Actual outcome is sometimes much better if the regimen is simplified to become practical rather than ideal. Some consumers are very sensitive to the "dose" of medication, and they prefer to take a medication with fewer milligrams even if this is explained as being an unimportant consideration. Other consumers are sensitive to the number of pills they are taking, and would prefer taking 100 mg tablet than three 25 mg tablets even though the dose is higher with the one pill.

Help the consumer use pillboxes and other packaging that assists in consistent medication use. At times, the pharmacy can set up assistive packaging, or perhaps a friend can help the consumer setup a pillbox system. Be aware of barriers to obtaining medication. Co-pays that seem small may still be enough to discourage medication use. Just getting to the pharmacy or the embarrassment of asking for a psychiatric medication at the pharmacy may all present barriers to obtaining medication. At times, clinicians may be only vaguely aware of insurance changes or prior authorization requirements that are overwhelming to a consumer. A pharmacy's decision to change from one brand of medication to another may make a consumer uncomfortable about taking the new pill and lead to a decision to just stop taking it.

Take a Long-Term Point of View. The Goal Is Not Just to Get the Person to Take Medication Today or Next Week. Consider the Impact of What You Are Doing Now on This Person's Willingness to Use Medication Next Year

Almost everyone who needs a psychiatric medication is likely to continue to need it for a considerable period of time. The issue is not just to "get the person on meds," but rather to work to help the person come to an understanding of his problems and of the role of medication as a potential solution to these problems. There is pressure to "medicate the person rapidly." It is desirable to keep periods of acute distress as brief as possible, to shorten periods of psychotic relapse, to decrease risk, and to shorten periods of hospitalization. On the other hand, the pressure to get someone "medicated" rapidly often requires pressuring the person to take a medication before he has had time to consider and absorb the various options. The pressure to "medicate" a person reinforces the locus of control of medication onto the clinicians and "other people," and decreases the opportunity for the consumer to consider whether and how medication might be useful. Taking a longer term point of view allows time

for the consumer to actively be involved in the decision of the goals and targets of the medication, what medication to take, how much, and for how long. This approach may require that it take a bit longer for the consumer to get onto an effective dose of medication. On the other hand, it may well make it more likely that the consumer will continue be on medication over time.

Not Everyone with Schizophrenia Benefits from Medication. This Means That When a Person with Schizophrenia Says That the Meds Do Not Help, At Least Some of the Time They Are Being Objectively Accurate

While it is clear that groups of people with schizophrenia will have fewer positive symptoms and fewer periods of relapse if they consistently take antipsychotic medication, this does not mean that every individual will benefit from these medications or benefit to the same extent. Some people with schizophrenia may get little or no benefit from antipsychotic medication. Others may find that the marginal benefit of medication is outweighed by the side effects. The idea that medication is not always required is heresy. There is a risk of even broaching this reality.

The belief in the efficacy of medication has become so imbedded in our treatment programs that we cannot even seriously discuss it. Many people who say that the medication does not help are probably misguided, and that for many of these people medication helps in very clear, objective ways based on their own history and changes in their own behavior. On the other hand, when someone says that the medication does not help, we should at least listen and think about what we know about this person's response to medication. If we were true empiricists, it should not be all that unusual to pick up the chart of a person with a note that indicates the person has schizophrenia with active psychotic symptoms, and has failed to have significant benefit from multiple trials of antipsychotic medication including clozapine; therefore all medication is being discontinued. The reason we do not ever see such a note is because of the clinician's irrational belief in the power of medication, our unwillingness to admit impotency, and the pressure on the larger system to continue to prescribe medication whether it is effective for this person or not.

For the Vast Majority of People with Schizophrenia, Shared Decision-Making Is Not Only Possible but Leads to Better Outcomes

Shared decision-making refers to having the consumer and the prescriber come together to collaboratively make decisions that best fit the consumer goals, values, and preferences. There is an explosion of interest in shared decision-making (Deegan and Drake 2006). Unfortunately, actually implementing it is surprisingly difficult. Shared decision-making is much more than just sharing information

True participation in shared decision-making requires that all parties become educated about the range of treatment options. This means that the consumer needs way to become educated about the various treatment options, and that the prescriber becomes educated about the consumer's goals and values. Both sides of this education can be difficult. Historically, consumers have been provided with information about their medication. Such information is often overwhelming, always incomplete, and inevitably biased by the preferences of the person providing the information. Written information is often lists of indications and side effects. While such information is a start and helps to at least open the conversation, it usually does not give the consumer enough information to become a true part of a shared decision process. Too often, this written information provides information that is only vaguely useful to the consumer trying to absorb and comprehend it all (Shrank and Avorn 2007).

Web sites are another typical source of information for consumers, but again all such sites organize information based on their own biases. It is difficult to know which web sites provide reliable information and which do not. Even the idea of "reliable information" is problematic.

The authors of a web site or informational pamphlet will inevitably feel that medication is useful or that medication is dangerous. What one person sees as "reliable," another person will see as a polemic. Some information is much more reliable and balanced than others, but it can be difficult for a consumer to sort this out.

These concerns have led to the development of "decisional aids," structured ways of presenting information starting with the consumers own preferences, goals, and concerns. For example, is the consumer more interested in a medication that is most likely to help decrease voices, or more likely to avoid weight gain? Is the person more concerned with feeling "drugged out," or more concerned about not sleeping? The information about options can then be filled in, within this structure. Education can be based on the persons' own stated concerns. These decision aids are different than just an article or book about treatment options or medications, and tend to help consumers work through complicated information to arrive at a decision that works for them. Some of the decision aids are on paper, while others involve computer technology that allows for better customization of the information flow to fit each consumer's needs. The better ones use concepts and language that are "consumer friendly." Most importantly, they provide information based on the consumers own needs, so that it can be directly applicable to helping consumers to be true participants in the decision process. WRAP plans (wellness recovery action plans) are one form of a decisional aid (Copeland 1997).

Having information is necessary but not sufficient for having a true voice in decisions about one's own life. It requires that the prescribers and other formal decision-makers become willing to share power with the consumer, not just when the consumer's decision happens to agree with that of the prescriber. This in turn requires that the prescriber may need to support decisions that he or she would not necessarily choose. There is a range of such disagreement, from differences of opinion that can be easily tolerated and supported, to those that appear particularly self-defeating and dangerous. Part of the process of shared decision-making requires developing a process to discuss and arbitrate these disagreements, when prescribers disagree with consumers and when consumers disagree with prescribers. This also requires that both consumers and prescribers receive training in the implementation of shared decision-making.

Shared decision-making is more than just another technique to convince a patient to do the right thing. Rather, it is a way for reestablishing a more collaborative, less hierarchical relationship. The relationship between physician and patient is equal but asymmetrical. Patient and physician have different sources of information, and different kinds of expertise. Shared decision-making requires that the physician relinquish certain kinds of control, even in the face of a variety of professional and societal pressure to maintain control. It requires that the consumer take on the burden of learning about his illness and treatment options in a serious way, and then taking on the responsibility for his own decisions. It requires time to enter into this collaboration, and it requires the development of decision aids that can assist the process. Shared decision-making is not equally applicable in every situation, nor will it resolve all conflicts about medication decisions. At the same time, Shared decision-making is an approach that is likely to allow more collaboration and less conflict, and as a result lead to better outcome.

There is no way to ensure that the consumers will always agree with our view of the problem, or our suggestions about treatment. Consumers may decide to stop taking medications that we feel are extremely helpful and even necessary. We will, at times, attempt to use various kinds of pressure or even legal sanctions to force the use of medications, at times over the strident objections of the consumer whose life it is. There will be some situations where it will be difficult to find areas of common ground for an understanding of the problem or the solution. At the same time, without being naive about the difficulties that can ensue, it is imperative to try to understand the world from the consumer's point of view. It is important to look for areas where we can overlap with the consumer in a common view

of the problem. It is useful to think of medication as a tool that the consumer can use to facilitate his or her own recovery journey. It is hoped that this reframing of the role of medication will lead to better long-term outcomes than more traditional ways of thinking about compliance and adherence. Our goal is not to get consumers to take their medication but to help consumers get closer to their own recovery goals. Our job is to help consumers learn to use medication to facilitate this journey.

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28 Integrated Family Psycho-Education: Helping Families Help Their Loved Ones Recover

Susan M. Deakins and William R. McFarlane

The prevalence of schizophrenia spectrum disorders (SSD) according to the National Institutes of Mental Health is 1.1%. Most of the 2.4 million Americans directly affected by these disorders manifest the earliest prodromal symptoms of the disorders while still living with their parents and siblings whose lives are also deeply affected. It is not surprising that a treatment called family psycho-education (FPE) has evolved over the past several decades since the advent of deinstitutionalization to help family caregivers help their ill members whom they love and themselves as well. The participation of family members in FPE is a crucial factor in the current effort to prevent the progression of the prodromal phase of the illness to the psychotic phase (McFarlane 2002).

Several exhaustive reviews of FPE exist in the literature (Dixon and Lehman 1995; Dixon and Adams 2000; Dixon and McFarlane 2001; McFarlane et al. 2003). FPE was first developed and shown to be efficacious for the treatment of SSD. Subsequently, FPE interventions have also been developed for bipolar spectrum disorders and major depressive disorder. This chapter discusses the use of FPE in SSD and describes the essential elements of FPE and their delivery in a single-family format (SFPE) or a multiple family group (MFGPE).

It is not by chance I (S.M.D.) find myself writing this chapter. I grew up in a family in which the family trees of both parents included people who suffered from severe mental illness (SMI): my mother's great-grandmother, my father's mother, and my younger brother. The story of one and my direct experience of the other two have given me a personal sense of how the care of the SMI has changed over the past 150 years.

My mother's great-grandmother was the wife of a prominent business man of his day. When she became ill, he provided a separate apartment and a German physician to care for her until she fell in love with him and got himself fired. After her husband's death she married a "spiritual" shyster, who tried to steal her inheritance. Her son and grandson, my grandfather, went to court to testify to her long-standing insanity dating back to 1855. An upper class example to be sure, but nonetheless one that illustrates the family's responsibility for the care of a mentally ill family member in America in the mid-nineteenth century.

By the time my paternal grandmother became mentally ill, the asylum was the locus of care. My grandmother lived half of her life in an asylum and died there. Occasionally, she came home to visit my Aunt Ruth, her oldest daughter. When I was nine, she came to our house for

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Thanksgiving. She was hallucinating and spoke to no one, and no one spoke to her. When she was no longer able to come home, Aunt Ruth drove to the asylum every Sunday to bring her a home-cooked meal. One hot summer Sunday I accompanied her. The windows of the asylum were open, and, as I waited for my aunt to return, I heard the constant mumbling of the patients talking to themselves. After my grandmother's death Aunt Ruth shipped her body back to the southern town where she had grown up and had her buried in the family cemetery.

My younger brother's care took place in the community and relied heavily on the use of medication. The wealth of evidence-based psychosocial practices (EBP) available today had not yet been developed. During the summer and fall of 1957 my older brother graduated from college and married, my father had a heart attack and lost his job, and my younger brother went off to college. Between Thanksgiving and Xmas he suffered his first psychotic episode. At Xmas my family picked me up at the airport and on the long drive home said nothing. I opened the front door and saw my brother cowering in the corner over the heating vent in the living room floor, his hands clasped over his head and his body rocking back and forth.

He was hospitalized several times during which my mother spoke briefly with several different social workers but with no follow-up after discharge. Early in the course of his illness my brother lived in his own apartment in another city and volunteered at the university hospital where he had most recently been an inpatient. He made a serious suicide attempt by overdosing on pills, and, when he needed surgery for his decubitus ulcer, my mother decided to bring him back home. The psychosocial programs in the city where my family lived were limited, and his relationship with his medicating doctor was little more than pro forma. After the death of both parents, my brother continued to live in the family home with an alcoholic friend. His social network was small—the town postmistress, a few local shopkeepers, and several nearby neighbors. In his 50s he stopped his antipsychotic medications and shot himself. I honored his wishes to be cremated and have his ashes strewn from Signal Point, a ridge on the mountain where we lived which overlooked a river and an opposing mountain range. He wanted a thunderstorm, but the day was sunny and the sky blue. I was grateful my parents had predeceased him and did not have to grieve his loss a second time.

Not long ago a paternal first cousin told me his deceased mother, the youngest of my father's three sisters, had never told him the story of our grandmother. While my brother was alive, no immediate or extended family members spoke openly about his illness, an example of internalized stigma among family members.

During the 1950s the advent of thorazine and the congressional extension of income support to the disabled under the Social Security Act set the stage for the emergence of deinstitutionalization as state government policy during the 1960s. The families of the mentally ill became de facto caretakers with little appreciation or support until the development of the National Alliance for the Mentally Ill (NAMI) in 1979. Acute psychiatric care was transferred to the psychiatric inpatient unit of the general hospital and long-term follow-up took place in the hospital outpatient clinic or in a community mental health clinic after the Kennedy Federal Community Mental Health Services Act of 1963. Once again families dealt with all but the acute psychotic phase of the illness by themselves. One essential weapon had been added to the armamentarium: antipsychotics. Although clearly an advance, it was a mixed blessing for families. Medication helps only when taken. For the first time families faced the possibility of medication non-adherence as a source of conflict.

Many young psychiatrists in training today encounter families of the SMI primarily during the acute psychotic phase of the illness in the emergency room and on the inpatient unit. In both locations the primary focus of the contact is to obtain the details of the patient's history. The resident may join the meetings between the social worker and the family on admission and prior to discharge and offer some information about the illness. At New York Hospital 20 years ago families participated in eight family sessions

during the first 3 months of inpatient treatment. Measurements were taken on admission and at 6 and 18 months. Information about the patient's post-discharge treatment was not obtained and made interpretation of the cause of any positive outcomes impossible (Glick et al. 1990).

One of the family recommendations of the PORT Updated Treatment Recommendations 2009 (Dixon et al. 2010) states that "Patients who have ongoing contact with their families should be offered a family psychosocial intervention that spans at least 9 months and provides a combination of education about the illness, family support, crisis intervention and problem-solving skills" and that "such interventions should also be offered to non-family caregivers." Randomized controlled trials (RCT) of FPE have repeatedly demonstrated that, together with appropriate pharmacotherapy, 1–2-year relapse rates can be reduced from 40 to 53% to relapse rates of 2–23% (McFarlane et al. 2003). The PORT Client Survey in 1998 reported that, in two states which were studied, 84.5% of inpatients and 77.2% of outpatients had some ongoing contact with their families during the past year. In State A 40.8% of inpatients and 37.2% of outpatients were offered or received a family service. In State B only 26.8% inpatients and 13.9% outpatients were offered or received a family service. Twenty-three percent of rural outpatients were offered a family service compared to 5.1% of urban outpatients (Lehman and Steinwachs 1998).

In many states families are referred to a local NAMI chapter on discharge. NAMI offers weekly meetings and a 12-week course, family-to-family (FTF), lead by trained family members. The total budget allocation for family services in many states goes to cover the cost of the materials needed by local NAMI chapters for these educational series. Recent data from the first RCT of FTF (Dixon et al. 2011) supports the idea that the program may warrant designation as an EBP. It is "the most widely available and used education and support program for family members of people with mental illness" and the least costly.

The PORT Updated Treatment Recommendations 2009 also states that "family therapies based on the premise that family dysfunction is the etiology of the patient's schizophrenia should not be used." In Great Britain at the time of the relocation of long-term mental hospital residents to community settings (Brown et al. 1972), the worst resettlement outcomes occurred in consumers living in hostels devoid of warmth and support. The next worst outcomes occurred in households where patients lived with parents or spouses. Further investigation established family factors that help consumers achieve stable recovery, i.e., supportive comments and emotional warmth and other family factors, i.e., emotive criticism and intrusiveness that predict a relapsing clinical course. The term "expressed emotion" (EE) has become a troubling construct synonymous with the negative interpersonal factors referred to as "high EE." These factors have unfortunately come to be regarded as dysfunctional family traits rather than changeable reactive states resulting from living with a difficult illness without support and understanding of the illness. Family members, especially mothers, no longer feel blamed for causing the illness, but instead feel accused of worsening its course. Despite the negative feedback on outcomes for consumers residing in alternative residences and hostels, these forms of housing continued to be developed. Only a small group headed by Robert Lieberman tried to help families who were stressed and burdened by caring for their chronically ill member. The group worked with families and consumers together in both SF and MFG formats. The approaches they used—education about the illness, problem-solving, and communication skills—became the bedrock of FPE (Falloon et al. 1981).

Without FPE two factors determine the nature of a family's response to the appearance and ongoing presence of these illnesses: the length of time the family has been trying to cope with the illness and their level of stress. The level of EE begins to rise as early as the prodromal/early psychotic phase of the illness and continues to rise as the illness progresses towards the psychotic phase (McFarlane and Cook 2007). Hooley and Richters (1995) showed increasing rates of high EE during the first 5 years of the illness: less than 1 year, 14%; 1–3 years, 35%; >5 years, 50%. Without

FPE the designation of a family as high EE strongly predicts relapse, a finding that has been repeatedly replicated. Other factors correlated with increased levels of EE in families are attributing illness behavior to the patient, stigma leading to the family's emotional withdrawal from its social network, decrease in the size of its social network, increase in its burden, and ultimately social isolation.

The initial development of what is now called FPE and the demonstration of its effectiveness in preventing relapse and rehospitalization in SSD took place in the United States and Great Britain between 1970 and 1990. Anderson et al. (1986) and Falloon (1984) developed single-family models, and McFarlane (2002) used Anderson's structure in a multiple family group (MFG). Anderson's SFPE and McFarlane's MFGPE took place in the OPD of a general hospital or a community mental health center whereas Falloon's SFPE was delivered in the family's home.

All three models contain seven core elements, which are believed to be essential to help families achieve the goal of improving the course of the illness for the consumer:

- Empathic engagement
- Education about the illness, including guidelines for the family (Appendix)
- Ongoing support
- Clinical resources during periods of crisis
- Social network enhancement
- Problem-solving and communications skills training
- A minimum duration of 9 months

FPE is based on a collaborative relationship among professionals, consumers, family members, and other caregivers in an ongoing treatment and rehabilitation process comprised of cognitive and behavioral elements. It provides education about the psychobiology of schizophrenia plus training and ongoing guidance in problem-solving in a supportive social environment. Its primary goals are to improve the clinical, functional, and quality of life outcomes for the consumer using reduction of the family's stress as the indispensable means for achieving these outcomes. FPE rests on the empirically supported framework of the stress vulnerability model to understand SSD. This model regards these illnesses as disorders of brain function with a genetic/developmental base which makes the consumer particularly vulnerable to environmental and internal stress. It is the effect of these stressors on a vulnerable individual that produces the symptoms and deficits of a psychotic episode. A major goal of FPE is to teach families how to create a low stress environment by educating them about the effect of the disorder on the patient's sensitivity to stress and helping them create a low stress environment at home. The therapists model behaving in a low EE manner in all their dealings with the patient and the family whether seen together or separately.

The four stages of treatment correspond to the three phases of an episode:

1. The first two stages, engagement and education, with the prodromal/acute phase
2. The reentry stage with the recuperative phase
3. The social/vocational rehabilitation stage with the rehabilitation phase

Ideally engagement starts within 48 h of admission or the onset of psychosis, and the therapist who engages the family and the patient is the same person who follows them on an ongoing basis after discharge. In an MFG with six to eight families each co-therapist "joins" half the families. The therapist introduces herself to the patient and explains briefly that she will be meeting with the family and that, when he is feeling better, he is welcome to join. There are two meetings with the family alone to establish a collaborative relationship and to hear the family's experience dealing with the illness. The therapist continues to meet briefly with the patient, and, if possible, the patient joins the third family meeting. As with all subsequent meetings, these meetings begin with 10 min of socializing (the "chat") and end with 5 such minutes at the end. The therapist says something about herself, e.g., what baseball team she prefers or how difficult it was getting to work because of the flooding. She also offers to help the family with a current, concrete problem, e.g., the family has been trying to speak with the doctor about a pain the patient has been complaining about recently and wants to know if there is

something physically wrong or if it is related to his mental illness. The therapist offers to speak to the doctor and get back to them with the results.

In both SFPE and MFGPE, the education stage takes place on a weekend in six 1-h sessions. As many family members as possible are encouraged to come, including the patient if he is sufficiently stable and wants to come. Lunch is served, and there is a morning and afternoon coffee break during which the clinicians act as hosts and hostesses. The room is arranged as a classroom and the curriculum is presented by relevant staff using lectures, slide presentations, Q and A, and other available technology. The bio-psychosocial information about the disorders and the guidelines for managing the illness are presented plus information about how the clinicians, patients, and families will continue to work together. The families in Anderson's SFPE enjoyed the group so much that they asked whether the group could continue to meet monthly. Realizing the benefit to the families' network, Anderson granted their request and altered the protocol. The MFGPE model was likewise conceived by family request.

The reentry stage/recuperative phase follows the workshop and continues through the rest of the first year. In SFPE each family including the consumer meets twice a month with the therapist. The families in the MFGPE, including the patients, meet with the co-therapists with the same frequency. Aside from the first two meetings of the MFG and what is called the "go-around," the basic format of SFPE and the MFGPE is identical. SFPE meets for an hour and the MFGPE for 90 min.

As mentioned earlier, each session in both modalities begins with 10 min of socialization followed by the "go-around," a quick review of what has happened in each of the families in the intervening 2 weeks, starting with the family who generated a task that resulted from the prior session's problem-solving.

During the first session of the MFG, the family members introduce themselves and talk about their lives before the onset of the illness. Often there are activities they have been unable to pursue since the illness began. One goal of the group is to help families decrease their social isolation and encourage them to return to activities they previously enjoyed.

During the second group the families share their experiences living and coping with the illness. In the groups that follow the "go-around" follows the "chat." The co-therapists chose the problem the group will problem-solve. The problem is clearly defined, and all group members, including the therapists, offer solutions. The pros and cons of each proposed solution are listed and discussed. No suggestion is rejected outright without its pros and cons having been discussed. Ultimately, the family decides which suggestion it wants to try. The suggestion is transformed into a specific task (who does what, when, where, with whom, and how often). At the beginning of the next group's "go-around," the family reports the results of the task. If there were any snags in the execution of the task, the co-therapists take responsibility by indicating that they had missed some important information and then set about finding what it was. When they discover what had been overlooked, they revise the task accordingly. Over a 12-week period, every family has a chance to have the group solve one of its problems. In the interim they hear solutions suggested for other families' problems. An interesting phenomenon in MFGPE is cross-parenting where a parent from one family is able to help a consumer in another family solve a problem which the consumer's parents had been unable to solve.

FPE is a front-loaded treatment, i.e., multiple joining sessions, the workshop, the first two meetings, learning the format, i.e., the opening "chat," the "go-around," choosing the problem, problem-solving (pros and cons), developing the task, and closing "chat." When the therapists are "in the flow," the co-therapists can sit back and let the group be the driver. Both formats offer families and patients a place to talk about parts of their lives that they are uncomfortable discussing in other contexts. By realizing they are not alone in dealing with such problems, stigma is reduced. Once the symptoms of SSD are demystified and ongoing support is available, families come to realize it is an illness with which they can cope and be of help in the consumer's and the family's recovery process.

After the first year the focus of treatment shifts to finding work and people with whom to socialize. To keep the level of stress at a manageable level, the consumer decides which of the two areas he wants to address first. The frequency of the meetings decreases to once a month. The longer the treatment continues, the greater the benefits.

Conclusion

If one plans to work with people suffering from SSD, it is crucial to appreciate the important role of the family. Persons with these illnesses who currently have no contact with their families might have been spared this alienation had they and their families had the opportunity to be treated in SFPE or MFGPE early in the course of the illness. Recent exciting work using MFGPE as the means to lower the stress as early as possible and prevent the first psychotic episode in young people identified in the community in the prodromal phase offers a chance to optimize the course of the illness.

FPE needs to be integrated with the treatment of SSD just as Integrated Dual Diagnosis Treatment (IDDT) has been. At least 50% of persons suffering from SSD have co-occurring substance use disorders (SUD) for which IDDT is indicated. In the prodromal/early psychotic phase of SSD most people are still connected to their families if not actually living with them. The dire consequences of not preventing the development of high EE or helping a family lower it if it has already developed are well known. These treatments are well grounded in research, and the rewards of helping the patient and the family live the best life possible are great.

Appendix: Guidelines

Here is a list of things everyone can do to help make things run more smoothly.

1. GO SLOW. Recovery takes time. Rest is important. Things get better in their own time.
2. KEEP IT COOL. Enthusiasm is normal. Tone it down. Disagreement is normal. Tone it down, too.
3. GIVE EACH OTHER SPACE. Time out is important for everyone. It's OK to reach out. It's OK to say "no."
4. SET LIMITS. Everyone needs to know what the rules are. A few good rules keep things clear.
5. IGNORE WHAT YOU CAN'T CHANGE. Let some things slide. Don't ignore violence.
6. KEEP IT SIMPLE. Say what you have to say clearly, calmly, and positively.
7. FOLLOW THE DOCTOR'S ORDERS. Take medicines as prescribed.
8. CARRY ON BUSINESS AS USUAL. Reestablish family routines as quickly as possible. Stay in touch with family and friends.
9. NO STREET DRUGS OR ALCOHOL. They make symptoms worse and prevent recovery.
10. PICK UP EARY SIGNS. Note gradual changes. Consult with your family physician.
11. SOLVE PROBLEMS STEP BY STEP. MAKE CHANGES GRADUALLY. WORK ON ONE THING AT A TIME.
12. LOWER EXPECTATIONS TEMPORARILY. Use a person as yardstick. Compare this month with last month rather than last year.

    Anderson et al. (1986).

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Part VI

Heroes: Promising Practices and Interventions

29 The Role of Psychiatry in Permanent Supported Housing

Sam Tsemberis, Benjamin Henwood, Van Yu, Alexa Whoriskey, and Ana Stefancic

Introduction

Permanent Supported Housing (or as it is sometimes known—Permanent Supportive Housing [PSH]) is a general term that has been used since the mid-1980s to describe an approach that combines the provision of permanent, affordable, or subsidized housing and intensive individualized treatment and support services for people with severe psychiatric disabilities. The type of housing varies and exists on a continuum from individual independent apartments scattered in the community to large single-site congregate residential buildings with anywhere from 15 to 100 units, with occasional buildings having hundreds of apartments. Support and treatment services for these two types of housing also vary with services for tenants in scattered-site apartments provided by off-site interdisciplinary teams, while for those living in congregate settings, services are provided by clinical staff that is on-site, with offices and program space as part of the building. While the structural and operational features of supported housing programs vary, their overall goal is to improve social integration and quality of life of people with psychiatric disabilities, to reduce the problems people have in achieving stable housing and to increase the potential for successful recovery from psychiatric disability.

Although mental health and other services are distinct domains from housing and rental assistance, the need for supported housing stems from the complex relationship between the two. For example, effective psychiatric intervention can help prevent housing loss or make accessing housing more likely. At the same time, stable housing makes psychiatric stability more likely and accessing care easier. In both cases, the manner in which treatment and housing are provided can affect housing retention and quality of life. This chapter describes the development of the congregate and scatter-site models, evaluates these approaches, and describes the role of psychiatry within each model.

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The Need for Supported Housing

Responding to Unnecessary Institutionalization

Throughout the era of deinstitutionalization, many people with prolonged psychiatric disabilities remained confined to custodial settings, such as so-called adult homes, other residential care facilities, nursing homes, and board and care settings. Supported housing models were developed at a time when it was acknowledged that the general failure to focus on housing and support had contributed strongly to unnecessary institutional care for up to a third of all people in psychiatric hospitals (Department of Health and Human Services [DHHS] Steering Committee 1980). In recent years, tens of thousands of people with prolonged psychiatric disabilities have also been homeless, inappropriately jailed, or in and out of acute care settings such as emergency rooms and detox treatment where they generally lack access to adequate effective long-term treatment (Torrey et al. 1992). Others are housed in transitional settings such as shelters, safe havens, and transitional housing programs where the prevailing treatment philosophy is maintenance, stabilization, and working on readiness for housing.

Supported Housing is consistent with the Federal Government's mandate to end the social and residential segregation of people with psychiatric disabilities in restrictive settings. The New Freedom Initiative (http://www.hhs.gov/newfreedom/), a comprehensive program to promote the full participation of people with disabilities in all areas of society, emerged from President Bush's New Freedom Commission on Mental Health in April 2002. Led by Michael Hogan, the Commission concluded that, in order to facilitate treatment and recovery, people with psychiatric disabilities need access to affordable, permanent housing coupled with flexible, individualized supports (DHHS 2003).

The community integration mandate expressed by the New Freedom Initiative has its legal roots in the Americans with Disabilities Act (ADA) of 1990. Among its many provisions, the ADA prohibits States and localities from discriminating against people with disabilities and/or excluding them from participating in, or benefiting from "services, programs, or activities of a public entity…" 42 U.S.C. Section 12101.

Furthermore, the Department of Justice (DOJ), which enforces Federal laws, interpreted the ADA's anti-discrimination provision to mean that States and localities must provide services to people with disabilities in integrated settings, meaning "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R., part 35, section 130 and Appendix A.

In a landmark case originally brought by two women confined to a state hospital in Georgia, the U.S. Supreme Court affirmed that unnecessary institutionalization is a form of discrimination prohibited by the ADA. In Olmstead v. L.C. (1999), the Supreme Court based its finding on two observations about the effects of providing services to people with disabilities in institutional settings:

> First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.

In 2010, more than 10 years after the original Olmstead decision, the state of Georgia finally entered into an agreement with the federal DOJ to dismantle its state psychiatric hospital system through transitioning many patients to supported housing programs. Similar court decisions based on the Olmstead decision have rendered favorable rulings for people with psychiatric disabilities and the number of filings of Olmstead violations is now rising across the United States, highlighting a much needed shift to providing supported housing for people with psychiatric disabilities (Padgett and Henwood 2011).

People with Psychiatric Disabilities and Homelessness

A major driving force for the past 2 decades for the development of supported housing is the emphasis on ending homelessness for people with psychiatric disabilities. There are disproportionately high rates of homelessness among people with psychiatric disabilities ranging from 30 to 50% (Susser et al. 1997; HUD 2008). The enormity of this unfortunate correlation is all the more disturbing considering that incidence of severe mental illness in the general (domiciled) population is approximately 3% (National Coalition for the Homeless 2008). While a complete discussion of these issues can be found in the chapter on homelessness in this volume (see Chap. 33), the focus in this chapter is to point out the problems people with psychiatric disabilities incur as they compete for a declining number of affordable housing units in the context of a federal policy that has abandoned any significant commitment to developing new affordable housing for people with low incomes (Hartman 1986; Baxter and Hopper 1984; Hutchings et al. 1996; GAO 2000; Bianco and Denton 2001).

Poverty is a root cause of homelessness. Poverty is what all people who are homeless have in common. People with a psychiatric disability receiving Supplemental Security Income (SSI) are among the poorest of the poor. This subsistence allotment generally does not exceed 25% of local median incomes. Standards for affordability, set in Federal policy in the 1940s, deem that households are cost-burdened when housing costs (including utilities) consume more than 30% of total household income. Those paying more than 50% of total income are considered severely cost-burdened and are viewed as having worst case housing needs (Cooper and O'Hara 2002). In a national survey examining the housing options for people on SSI, Cooper and O'Hara (2002) found that, in general, people with psychiatric disabilities receiving SSI need to pay 105% of their monthly income to rent a modest one bedroom apartment using the federal standards for fair market rent and affordability, not to mention additional funds needed for utilities or telephone costs. They conclude that once homeless, people with psychiatric disabilities are "priced out" of the rental market and are likely to remain homeless without any option to attain mainstream housing if they do not receive some additional form of rental assistance.

Housing discrimination further explains vastly disproportionate high rates of homelessness among people with psychiatric disabilities. Discrimination based on stigma surrounding mental illness remains rampant, despite nondiscrimination mandates established in the ADA (Allen in Hutchings et al. 1996). Racial disparities also exist within the population, with African Americans reporting more days of homelessness and poorer housing conditions (Goldfinger et al. 1999; Uehara 1994).

Two Approaches to Supported Housing

As mentioned above, permanent supported (or supportive) housing programs for individuals who are homeless with psychiatric disabilities are characterized by two dominant approaches—scatter-site and congregate—that have a number of dimensions in common. Both approaches recognize the need for a permanent, affordable place to live, the importance of safe and decent housing, having a sense of home and community, and easy access to clinical care and support. The tenant's rent is subsidized by the program, and most tenants do not pay more than 30–40% of their income towards rent. Despite overarching similarities, the two approaches also vary on a number of dimensions including choice of housing, level of supports, criteria for admission and retention, extent to which housing and treatment are separate domains, and the philosophy and clinical practice in which services and treatment are offered.

Congregate Housing Model

The first approach—single-site, congregate-supported housing—was developed before the scatter-site, independent apartment model. Organizations and government agencies that operate congregate programs typically begin by acquiring an older building and rehabilitating it into a program or starting with the purchase of land and constructing the building to house the program. These projects require about 3 or 4 years to complete and the program must secure and blend multiple funding streams, as well as establish committed partnerships among developers, contractors, and providers for the duration of the project. The buildings are typically comprised of numerous studio-like units and include shared common areas for dining, social, and recreational activities, and support and treatment services. Most buildings also have property management services on-site to maintain the building and provide safety. The buildings are typically well run and orderly management is achieved through clearly defined rules concerning visitors, use of common areas, overnight guests, drug/alcohol use, cleanliness, and other matters that provide structure and a safe and comfortable environment for residents and staff. Once accepted into the program, consumers move into furnished units equipped with the basic necessities; many include bathrooms and kitchen areas.

The tenant composition of congregate programs can range from 100% people with psychiatric disabilities to 50% with disabilities and the remainder a mix of neighborhood residents who meet income-tested eligibility criteria for rent subsidies, or people with other special needs. Clinical and support staff occupy office and program space in the building and typically meet program participants in their offices, although they visit tenants in their units as the need arises. On-site staff always includes case managers during the day and residential managers around the clock with other mental health professionals such as social workers, nurses, and psychiatrists typically on-site during the day, some part of the day, or some days of the week depending on the intensity of program services and the number of consumers in the building.

Congregate programs can vary greatly both in their structure and their requirements and include large residential care centers, small and medium size group homes, and mixed-use SRO (single room occupancy) buildings. Most are operationally and philosophically based on the therapeutic milieu or therapeutic community model where there is a focus on the individual as part of the community and the community of other residents is considered part of the treatment milieu. Most congregate, single-site programs require sobriety and participation in psychiatric treatment as a condition for admission. There are, however, a small number of single-site congregate programs that use a harm reduction approach to addiction. Once accepted, residents generally have rights of tenancy.

Scatter-Site Housing Model

The scatter-site model does not develop or build a building, but simply rents independent apartments from private market community landlords or assists tenants to rent available units. Start-up for a scatter-site program is immediate—some minimal apartment repair or painting may be needed, but no construction is involved. Apartments are located in neighborhoods that have affordable housing. The buildings in which the apartments are rented are structurally and in every way the same as any other building on the block. No greater than 20% of the units in any one building are rented by the program (or set aside for persons with disabilities) so that the majority of the building's tenants (80% or more) are people who live in that community. This is a deliberate effort to actively promote the inclusion of people with psychiatric disabilities into normative community settings, which the research on psychiatric rehabilitation shows is the most effective way for a person to learn independent living skills (Blanch and Anthony 1989).

Clinical and support services are located off-site and provided by mobile interdisciplinary teams that make house calls. The support

services among programs can vary depending on the consumers they serve. Typically, Assertive Community Treatment (ACT) teams are utilized to support people with severe or complex needs and Intensive Case Management (ICM) teams for people who either graduate from ACT or who upon admission have only moderate clinical needs. Although scatter-site apartments provide increased opportunities for program participants to interact with people outside the mental health system as compared to congregate models, those living independently may spend more time alone since they are not obligated to interact with other consumers and have no on-site clinical or support services. It is important to note, however, that while some people report feeling lonely in their apartments, they still prefer independent to congregate housing (Yanos et al. 2004).

The Pathways' "housing first" model is the prototype for scatter-site programs (Tsemberis 2010). It offers immediate access to permanent, scattered-site housing and combines flexible, community-based services such as ACT or ACT-like ICM services (Tsemberis 1999; Tsemberis and Asmussen 1999). A key feature of the housing first model is that it does not require sobriety or participation in psychiatric treatment as a precondition for getting or keeping independent housing. This separation of treatment and housing provides the program considerable flexibility and allows the clinical services to operate effectively and maintain treatment even through housing loss or housing changes. In housing first programs, loss of housing occurs only for lease violations and not for program rule violations, treatment noncompliance, or hospitalization. There is also a commitment to rapid rehousing in the event of housing loss.

The Continuum of Care and the Two PSH Models

Both models of supported housing were developed to address homelessness for people with psychiatric disabilities. The single-site congregate approach was widely adopted because funding for this model was readily available through the federal government's office of Housing and Urban Development (HUD). HUD's initial response to homelessness was to propose and fund a loosely connected network of programs called the "Continuum of Care." It was assumed that people with psychiatric disabilities needed treatment first as well as to learn skills that would prepare them to eventually live in permanent supported housing. Thus, consumers are expected to work their way through a series of placements typically starting with drop-in centers or shelters, through transitional housing, and finally into permanent supported housing, by demonstrating compliance with psychiatric treatment and sobriety (Henwood et al. 2011). The Continuum is still the dominant funding mechanism for homeless services today.

The "continuum approach" is now slowly being replaced with approaches that eliminate transitional programs and treatment and sobriety prerequisites in favor of approaches that provide housing first, then treatment. Many congregate programs grew out of the continuum approach, but recently developed congregate programs are generally conceived as permanent supported housing and not as part of a continuum (Hopper and Barrow 2003). On the other hand, the scatter-site model has always been associated with permanent supported housing and is more compatible with the philosophy of psychiatric rehabilitation that emphasizes a recovery-orientation and consumer choice (Ridgway and Tsemberis, in press). The early model of scatter-site supported housing is well described in a number of articles and chapters where the principles and concepts of the model are contrasted with the traditional continuum of residential care programs (e.g., Blanch et al. 1988; Carling and Ridgway 1987).

The values and clinical practice of the housing first scatter-site program are based on the principles of psychiatric rehabilitation, the advocacy of the consumer movement including a "radical acceptance" of the consumer's point of view, and harm reduction practice. The housing first model is a human rights approach based on the belief

that housing is a basic human right, not something that must be earned through demonstrating sobriety or participating in psychiatric treatment. Consumer choice is at the heart of this approach: starting with the way it offers immediate access to decent, safe, affordable, and permanent housing of the consumer's choice to the manner with which it offers intense but flexible clinical and support services with a harm reduction philosophy in which consumers choose the type, sequence, and intensity (Carling and Ridgway 1986; Ridgway and Zipple 1990; Hutchings et al. 1996).

Evaluating Permanent Supported Housing

By the early 1990s, given advances in the field as well as cost and outcome studies showing the benefits and savings realized through immediate placement into PSH, the scatter-side model came to represent the state-of-the-art or "best practice" in the field according to the National Association of State Mental Health Program Directors (Hutchings et al. 1996). While there is varying empirical support for both the congregate and scatter-site models, historical and contextual factors within mental health system and housing policy make direct comparisons difficult. This is complicated by the fact that the newer housing first philosophy that was originally associated only with scatter-site programs now influences congregate programs as well. The differences in populations served by the congregate and scatter-site models further complicate comparisons of model effectiveness: many of the people admitted to scatter-site programs could not meet the admission criteria or comply with the structure and rules of most congregate programs. To date, there is still no empirical evidence indicating that clinicians can accurately predict which consumers will succeed in what type of housing. In this vacuum of empirical evidence, some clinicians strongly prefer to refer consumers with severe problems to congregate housing simply based on their belief that consumers need the higher structure provided by those programs. On the other hand, some clinicians acknowledge that these same consumers are least likely to succeed in structured programs and need housing and services that are more flexible. Finally, faced with the same situation, there are clinicians who will encourage the consumer to make the decision about which type of housing and supports they prefer.

Most organizations operating congregate housing programs require sobriety and compliance with program rules as a condition for creating a secure and comfortable living environment for all. In these environments, many consumers are at similar stages in their recovery and find support from their peers for maintaining sobriety and entering treatment. However, for some segments of the homeless population–those who are in the precontemplation stage of addressing their addiction and psychiatric problems or those who consider their priorities to be getting housing and reducing their hunger and poverty–the requirements for sobriety and program compliance in congregate programs prove to be insurmountable barriers. The housing first scatter-site approach was in part developed to offer another housing and treatment option for this segment of the dually diagnosed homeless population. In contrast to the congregate model, this approach offers housing with no treatment requirements and only one program rule: the consumer agrees to a weekly visit by the team. The housing is community-based and fully integrated and the expectation is that the consumer will observe the terms and conditions of a standard lease. More informally perhaps, the consumer is also expected to observe the social norms of their building and community. Individual scatter-site apartments provide the opportunity for a highly individualized approach to working with consumers at various stages of recovery and allows for a wide range of individually tailored treatment designed to help each consumer move towards recovery at his or her pace.

Moving beyond a "two model" system, the Center for Mental Health Services and the Substance Abuse and Mental Health Services Administration have recently developed an

evidence-based supportive housing toolkit (SAMHSA 2010) that recommends evaluating programs based on six key principles. These principles were selected for the research and clinical evidence that supports their effectiveness in reducing barriers and increasing housing retention and consumer satisfaction, namely: (1) choice of housing; (2) separation of housing and services; (3) decent, safe, and affordable housing; (4) integration; (5) access to housing; and (6) flexible, voluntary services. Going forward, this framework will hopefully improve the overall performance of new and existing housing programs. Nevertheless, below we quickly review the existing empirical support for both the congregate approach and scatter-site approach.

Effectiveness of Congregate Housing

Several studies found positive outcomes for residents in single-site supported housing programs including maintaining housing stability for some period of time, reduced use of emergency services, and satisfaction with living situations (Andersen 2002; Barrow et al. 2004; Burt and Anderson 2005; Mayberg 2003). Unfortunately, despite placement into permanent housing, substantial numbers of residents do leave. A HUD-sponsored study of people who left and people who stayed in 28 different congregate-supported housing programs found that about half stayed 3 years or more, while close to half left the program. Only one third of those who exited housing went to stable alternative housing (Wong et al. 2006). This speaks to a need for better understanding of why some people do not succeed in congregate housing placements, which may include an inability or lack of desire to live with others, or difficulty or unwillingness to comply with policies deemed necessary for congregate living (e.g., curfews, rules about guests, sobriety). Perhaps these outcomes point to the fact that the tacit assumptions in the model, or the expectations that most people with psychiatric disabilities will be content living in a congregate setting for their entire lives, are not well founded. Personal choices and life events may require a housing arrangement that is different from a small studio: getting into a relationship, reconnecting with families, and having a child are among the most common. The challenge for these programs is how to best support a person with housing and services so that they do not lose their housing or services even as their life circumstances change. These findings also suggest the need for rapid rehousing policies in cases when congregate placements do not work out.

Effectiveness of Scatter-Site Housing

Numerous studies have demonstrated that housing first programs eliminate access problems and are able to serve even those considered difficult to house. Housing first programs reduce the use of acute care services, incur significant cost savings, improve clients' quality of life, and most notably, result in housing retention rates of 85% (HUD 2007; Larimer et al. 2009; Mares and Rosenheck, 2007; Tsemberis & Eisenberg, 2000). Nonetheless, congregate models offer immediate access to social contact, while those in scatter-site housing report experiencing loneliness, reinforcing the need for more research in order to understand both advantages and disadvantages to social integration in scatter-site vs. congregate housing models (Hopper and Barrow 2003).

The Role of the Psychiatrist in Congregate-Supported Housing

As has been described in the previous section, the two models of supportive housing seek to meet the broader psychosocial needs of consumers that include psychiatric services. Much of the day-to-day job of a psychiatrist working as a member of a treatment team in either congregate or supported housing approaches is largely the same. There is, however, some variation due to how services and housing are structured, thus requiring slightly different approaches to engagement and treatment. Below we describe the role of the psychiatrist in supportive housing more generally and include case vignettes. We note also how working within either congregate or supported scatter-site housing models may influence the role of psychiatrists.

Role Description

Team-Based Approach

In either model, psychiatry is usually delivered within a multidisciplinary team-based approach for improved care coordination, which is consistent with the general healthcare trend being legislated through the Affordable Care Act. Unlike traditional clinical settings that typically entail a one-to-one encounter in which psychiatrist and patient comprise a dyadic treatment team with little influence from others, psychiatrists at supportive housing programs are typically part of a larger service team. Psychiatric treatment is, in essence, one of multiple services that are offered to tenants.

A team approach to service provision is associated with multiple advantages. Having team members work with consumers in multiple settings and on multiple domains allows each team member to have access to a variety of information about the person, thus providing more data than any single service provider could access individually. For example, an employment specialist may know about symptoms a person experiences at work that the person does not express to his psychiatrist. Team members can share information and coordinate services and ensure that these services are not at cross purposes to each other. A psychiatrist and social worker can make sure they share a consistent psychological understanding of a person that promotes cohesive psychotherapeutic interventions, thereby supporting each other's practice.

One hazard of the team approach, however, is the risk of blurring boundaries between professional roles. When a single agency is responsible for housing and clinical care, even a role as clearly medical as medication prescribing can become partly a case management issue. Is the frequency of medication a person is receiving a decision to be made jointly with the psychiatrist, case manager, or both? If a person isn't paying rent, is the issue of money management a clinical or housing issue? Systematic, crystal-clear communication and disciplined, consistent spheres of responsibility are necessary to reduce potential blurring of roles and boundaries among team members and ensure optimal operation. Psychiatrists are ultimately responsible for the medications they prescribe, but also have a responsibility to ensure that other team members understand medication decisions. Social service staff also has a responsibility to consult with the psychiatrist if they have knowledge about a tenant's medication regimens, and jointly with the person, can develop a comprehensive, medication support plan. While changes in prescribed medication and support occur based on a medication's effectiveness and corresponding side effects, they also need to be responsive to an individual's daily routines that at times can vary from week to week.

It is important to note that simply colocating a psychiatrist with other disciplines such as social work and nursing does not make a team. Teamwork requires a coherent approach among team members, a shared practice ideology, clear open communications, mutual respect and understanding of roles, and separate, defined spheres of responsibility. Whether as a team leader or other member of the team, psychiatrists should support and nurture this kind of team work while at the same time keeping a clear eye on how decisions ultimately get made and executed to best serve the person within the context of their living situation.

Psychiatric Outreach and Engagement

Since supportive housing often targets individuals with a history of homelessness, there is often a need for assertive outreach and engagement because people who were homeless are often unable, or unwilling, to ask for or access traditional psychiatric services. There are many reasons that consumers are mistrustful or wary of engaging into psychiatric treatment. Often, people who are homeless have been hospitalized or brought involuntarily to the hospital and are apprehensive about—or frankly, suspicious of—psychiatrists and therefore actively avoid contact with traditional treatment settings. Another issue concerns the history of brusque treatment received in psychiatric and other healthcare settings where the offer of services was experienced as condescending, not useful, and of low quality

(Hopper et al. 1997). Still other newly housed tenants are mistrustful of any mental health workers or outreach workers (Kryda and Comptom 2009). Clinic overcrowding and frequent changes in psychiatrists also contributes to a distrust of mental health services. These are some of the experiential hurdles that a psychiatrist in a supportive housing setting may encounter and must dispel in order to engage the consumer in treatment. In general, the psychiatrist must demonstrate that this experience will be different from those in the past. To facilitate this, supportive housing programs provide a safe and familiar setting where there are many opportunities to interact with consumers in an informal and casual way that over time helps to build rapport and trust.

Outreach to formerly homeless people requires a psychiatrist to have a flexible clinical approach and to be able to address the low expectations that consumers have about the quality of services offered to them. A famous story of a bingo-playing psychiatrist is an example of the kind of activity a psychiatrist may engage in to build trust among people in supportive housing. Supportive housing tenants who are unwilling to go to the psychiatrist's office may be more receptive to being visited in their room or apartment, or some other common private space in the building. Many consumers highly value their autonomy; as such, outreach and engagement approaches that respect a person's space, expertise concerning his/her situation, and foster an experience of working together with clinicians have been shown to increase trust of service providers.

Psychiatric Treatment and Evaluation

Providing psychiatric treatment and evaluation in supportive housing poses some unique challenges not encountered in traditional practice and attention to social history is particularly important since investigating the circumstances that resulted in and maintained a person's homelessness often provides clues to a person's psychiatric condition. For example, a consumer may deny paranoid ideas but speak in great detail about an elaborate conspiracy that led to eviction. It is important to be attentive to the co-occurring conditions of a person's history: homelessness is often associated with victimization, addiction, abuse, and trauma.

Compared to the relatively controlled environment of a hospital or clinic, providing psychiatric treatment in a supportive residence requires a clinician to be flexible about the frame of treatment. Most consumers in outpatient settings have demonstrated motivation to seek treatment by virtue of coming to the office; in supportive housing, consumers are often motivated to see the psychiatrist as well; however, the desire often stems from wanting to ensure they can keep their housing rather than explicit desire for treatment. Sometimes, for consumers who continue to refuse to meet with the psychiatrist, a fairly comprehensive evaluation can be formulated based on staff interactions with the consumer and a psychiatrist's observations of that consumer. While some residents of supportive housing have been court-mandated or involuntarily committed to treatment, services are mostly voluntary, and the clinician must rely more on her ability to actively engage a person to participate in treatment. When working with people with histories of trauma, engagement is more effectively achieved (as described in the outreach section above) when the psychiatrist assumes a person-centered or "shared-decision making" (Deegan and Drake 2006) approach to psychiatric treatment. This approach considers the consumer as an active participant rather than a passive recipient of treatment.

Clinicians in supportive housing residences face some unique logistical challenges. For example, these residences were not designed solely with treatment in mind, so there may be limited clinical systems in place to monitor or support the taking of medication. Even at residences where medication monitoring is offered, procedures governing this may be inadequate or staff providing medication monitoring may be inadequately trained or supervised as compared to hospital or clinic settings. These logistical concerns often affect treatment decisions including choice of medications. For example, a psychiatrist may be less prone to choose medications that require regular blood monitoring, like lithium, because there is no feasible way to arrange for lab tests. Many people may be willing to engage in some kind of treatment, but unwilling to take

medication or willing to take only doses that are inadequate for therapeutic effect. In these instances, the psychiatrist must also be a psychotherapist to help the consumer to better understand the consequences of their decisions.

To adopt a person-centered approach, it is very useful to have a very good working knowledge of motivational interviewing (MI) techniques. For example, treatment of psychiatric symptoms is often not a primary goal of supportive housing residents. Many people, understandably, identify poverty or unemployment, not psychiatric illness, as their primary problem and attribute their problems to social, economic and political circumstances. MI techniques can help a person see that treatment may be of use in their primary goal of increasing their income by getting a job and may be thus more willing to accept it.

AR is a 45-year-old, single, unemployed, formerly homeless man diagnosed with schizophrenia, chronic, paranoid type, who does not use drugs or alcohol and who has no known medical problems, lives in a congregate housing program where services, including psychiatric treatment, are not mandatory. Mr. R meets with the on-site psychiatrist once every 6 weeks or so stating that he only does this to maintain his SSI benefits even though the psychiatrist has informed him that receipt of SSI is NOT contingent on his continuing to meet with the psychiatrist. Mr. R's thinking is chronically and consistently referential and paranoid. He reports that people are always monitoring him when he is out in the community and that he knows that some of these people, although he can't determine who, wish to do him harm (although he is consistently vague about what this means). Because of these fears, Mr. R isolates himself in his apartment and only ventures out to attend to basic shopping at night when there are fewer people out and about. He declines to take psychiatric medication that the psychiatrist believes may ameliorate his fears. Typically, he starts psychiatric sessions stating that he only attends these appointments to maintain his benefits and that he has nothing to talk about, but proceeds to speak about a variety of things, including fears about people. Often, he states that he appreciates that his apartment is a salvation from homelessness and that this program is keeping him housed, and that his primary goal is to maintain a place to live. Indeed, he always pays rent on time. In recent months he has engaged the psychiatrist in conversations about his time in the army, his childhood in New York City, and the relative merits of urban vs. suburban living. So, despite Mr. R's refusal to take psychiatric medication, and his ongoing referential and paranoid thinking, he describes himself as "content" and "appreciative." He effectively attends to his basic needs, and he has developed an effective working relationship with residence staff and his psychiatrist.

Psychiatric Consultation

Psychiatrists in supportive housing residences serve not only as treatment providers but also as behavioral health consultants and systems analysts for the teams with which they work. For example, a social service team may have difficulty engaging a consumer because of some systemic practice that actually exacerbates the consumer's symptoms, such as insisting on monthly extermination of a unit, despite no signs of infestation, for a person diagnosed with schizophrenia who believes he is being poisoned. The psychiatrist might identify this problematic practice and raise questions as to whether the practice is necessary or offer possible ways for the team to be more flexible. Supportive housing staff also frequently consults with psychiatrists about engagement with individual consumers, consumers' reactions to medication, understanding of symptoms and diagnosis, as well as other issues. These "hallway" consults can be opportunities for a psychiatrist to learn more about the program staff and its residents, contribute to the overall quality of program treatment, and provide education for staff.

Liaison

The psychiatrist is a valuable resource in creating effective links between the supportive housing staff and a consumer's other medical providers in the community. Psychiatrists can more easily contact other physicians, as well as more effectively communicate a program's observations to them or interpret information provided by the physician back to consumers and staff. The psychiatrist may also be able to work with an off-site physician to adjust treatment plans to take into account limitations specific to the residence; for example, to schedule evening medications earlier in the day when staff are available to assist consumers. The psychiatrist can also be quite effective at advocating for benefits, such as SSI or Social Security Disability (SSD), for which a psychiatric evaluation is often instrumental.

The psychiatrist can also coach staff to advocate for consumers and coach consumers to advocate for themselves.

Consumer and Staff Education

Education in diagnosis and treatment can be quite effective at helping both consumers and staff to better recognize and manage psychiatric symptoms. For example, education-based programs for consumers like wellness self-management (also known as illness management and recovery) have been shown to improve a variety of consumer outcomes. A psychiatrist has multiple venues for providing education including staff meetings, case conferences, lectures, and informal consultations for staff and groups, community meetings, and individual consultations with consumers. The psychiatrist must also try to identify training needs in an ongoing way and can play a role in quality assurance, ensuring that psychiatric or medical procedures are performed in accordance with agency standards.

Role Logistics

Scheduling

A scheduling system that includes not only the psychiatrist's encounters with consumers, but also time set aside for a psychiatrist's other activities including meeting with staff is essential to smooth functioning. Depending on the program, responsibility for maintaining the schedule can fall to staff, the psychiatrist, or collaboratively to both. However, even a well-conceived system of scheduling requires others systems to be in place to ensure that scheduled activities happen in a timely manner, including reminding consumers a day before appointments, trying to contact consumers who have not shown for appointments, or in some situations, having staff escort consumers to their appointments. A sample psychiatrist's schedule may include a sign-in meeting, seeing patients every 30 min for follow-ups, a lunch break, another round of follow-ups, attending staff meetings (alternating weekly between clinical rounds-style meetings, case conferences, staff trainings, or consumer community meetings), and finally a sign-out meeting with the liaison.

Although attention to time management is essential, there is a need to balance the rigidity of scheduling with the flexibility to meet individual consumer needs. Some consumers cannot tolerate more than a few minutes with the psychiatrist, while others may require more time than usual. Some consumers are unwilling or unable to keep scheduled appointments, but are quite happy to interact with the psychiatrist in a more informal, catch-as-catch-can manner. Similarly, individual psychiatrists will be more or less comfortable and effective with scheduling and flexibility. After all, part of the circumstances that often result in consumers (and psychiatrists!) having psychiatric treatment in nontraditional settings in the first place is an unwillingness or inability to tolerate the tightly scheduled structure of traditional treatment settings. Utilizing a psychiatrist's time thus requires a balance between being flexible enough to accommodate those who cannot tolerate too much structure and paying enough attention to scheduling to prevent the ineffective use of the psychiatrist's time. It is worth noting that because of this need for flexibility in interactions between residents and psychiatrists, it is generally more feasible to fund psychiatric time through contracts than through a fee for service model.

Staff Communication with the Psychiatrist

The most significant advantage a site-based psychiatrist has over a clinic or office-based psychiatrist is probably his or her access to supportive housing staff and their in-depth knowledge about a consumer, which makes psychiatric evaluation and treatment possible. Similarly, for staff, having access to the psychiatrist is invaluable to understanding a consumer and his treatment. However, access alone does not ensure optimal treatment; a psychiatrist's treatment orders and recommendations must also be effectively communicated among psychiatrist, program staff, and consumer. The psychiatrist will expect that appropriate staff will execute, without modification, *orders* about consumers'

doses and scheduling of medications, scheduling follow-up appointments, and making referrals to other medical providers. On the other hand, the psychiatrist may make *recommendations* about issues, such as housing placement, that program staff may accept at their discretion.

There are multiple strategies a program and psychiatrist can employ to ensure effective communication:

1. Sign-in and sign-out
   A program can identify a liaison between its staff and psychiatrist: a person who meets with the psychiatrist regularly, preferably each time the psychiatrist is at the site. A "sign-in" meeting is most useful for the psychiatrist to learn about what has been going on with consumers since the psychiatrist's last visit. It can also be a time to review the day's schedule and strategize about consumer appointments, such as how to do outreach with a tenant who frequently misses appointments. A "sign-out" meeting is most useful for site staff to understand the psychiatrist's treatment interventions, especially the timing of medication changes. A psychiatrist may decide and document a medication change early in the day, while the sign-out, when communication about this change happens, may not happen until the end of the day. Thus, at sign-out, the psychiatrist and liaison should decide when the medication change should take effect, taking into account time that might be needed to obtain new medications from a pharmacy. Obviously, if the psychiatrist decides a medication change should occur immediately, she should not wait for the regularly scheduled sign-out or for site staff to read about the medication change in the clinical note. Preferably, programs will have both sign-in and sign-out meetings regularly and can often include other staff to maximize communication exchange, especially during sign-out.
2. Clinical staff meetings
   Periodic clinical staff meetings with the psychiatrist can be a very valuable adjunct to the regular meeting between site liaison and psychiatrist. Clinical staff meetings, similar to hospital clinical rounds, serve to help site staff formulate, understand, and plan for the execution of treatment and service plans. There is also the opportunity to assess the effectiveness of treatment plans already in place. Case conferencing allows site staff to collaborate more thoroughly with the psychiatrist about particularly complicated or challenging consumers or clinical situations. Site staff should also consider inviting the psychiatrist to give trainings or lectures about psychiatric evaluation and treatment.
3. Phone calls
   The site psychiatrist should be available by phone to consult about emergent or urgent issues that arise at times when she is not on-site. Examples of situations to call the psychiatrist include consulting about missed or improperly taken medication doses, consulting about emerging or changing side effects, requesting that the psychiatrist contact the emergency room to communicate about a tenant who has been taken there, or consulting about a tenant's suicidal, dangerous, or nuisance behavior. Calling the psychiatrist, however, is not a replacement for calling "911"—which is required in certain situations, such as when an individual is violent. Generally, the site staff and psychiatrist should collaborate to decide when phone consultation is appropriate, since routine business matters, such as refilling of prescriptions, should be completed when the psychiatrist is on-site.

   In most cases, it is not advisable to have consumers be able to directly call the psychiatrist off-site. Preferably, consumers will contact the psychiatrist through site staff if necessary between visits. This reinforces the role of program staff as part of the treatment team with the psychiatrist and consumer. Since psychiatrists often have a limited number of hours compared to other direct service providers within supportive housing programs, additional phone contacts (during time that is not necessarily paid for but part of the psychiatrist's role) need to be managed effectively.
4. Clinical charting
   Supportive residences often do not have a formal medical record similar to hospital settings. However, a system is required to keep medical records that are complete, accessible to the

psychiatrist and other staff involved in the tenant's treatment, and inaccessible to unauthorized staff and other consumers. Psychiatrists will document treatment and interventions that are meant to be acted upon in a timely manner and such as appropriate staff, for example, the liaison to the psychiatrist or the tenant's case managers, should read and clinical notes the same day the psychiatrist writes them. The psychiatrist must be mindful of time-sensitive data, for example, medication changes, and should decide if she must communicate with site staff prior to their reading of clinical notes.

The Role of the Psychiatrist in Scatter-Site Supported Housing (Housing First)

Most of the role and function description above applies to both congregate and scatter-site housing programs. However, there are a few notable exceptions for psychiatrists working in scatter-site programs, particularly those using a housing first approach. One of the core tenets of housing first is that housing and services are based on consumer choice. This requires a psychiatrist to balance imposing his or her expert opinions or plans and allowing the consumer's input into the final decision regarding medication and treatment, including choosing not to participate in treatment at all. A second issue stems from the fact that consumers live in their own apartments and can choose whether or not to let the psychiatrist into their home. There is a significantly different power differential when consumers live in their own apartments rather than the dynamic in the congregate model where the consumer lives in a program where the psychiatrist (and other staff) is an employee. Another difference in the role of psychiatrist concerns the issue of risk taking and professional liability. Because support services in scatter-site are off-site where there is no on-site supervision, the program serves consumers who may be actively using substances and not taking medication, essentially living in situations where the psychiatrist (and the rest of the team) has little control over the outcome of the consumer's circumstances. Yet, there is an implied responsibility that is borne for the well-being of that consumer. Being able to assume and effectively manage this level of risk is a key dimension of the psychiatrist's role when working in this harm reduction approach. A final issue concerns strategies for engagement. Initially, consumers will eagerly engage in the program because they are almost universally interested in having their own apartment. However, once housed, they realize they have options: to be sober or not, or to take medication or not, or even to allow particular staff to visit them in their home or not. Since stages of change are issue-specific and not person-specific, an individual can be at different stages of change in different domains of their lives (e.g., in action for mental health but in contemplation for substance use). Effective engagement into treatment presents significant challenges when working in this model that shifts the power dynamics of the clinical relationship. Since housing is separate from treatment, clinician's cannot use continued tenure in housing as leverage to get consumers' alcohol or drug use under control. Housing first ends homelessness very quickly, but mental illness and addiction can have a very long course to recovery and expectations must be managed for both consumers and staff. This harm reduction approach requires tolerance, empathy, creativity, and patience on the part of the clinician. The primary goal of the clinician shifts from seeking specific outcomes to ensuring engagement at all stages of the treatment.

In instances where consumers' behavior results in a lease violation, the psychiatrist as well as the other team members must work closely with housing staff, the superintendent of the building, and sometimes with neighbors to ensure a speedy and effective resolution. If the decision is made to relocate the consumer, the relocation can provide an excellent opportunity for a motivational interviewing conversation regarding the pros and cons of drug use and the pros and cons of psychiatric treatment. Sometimes a clinical intervention is sufficient to avert a relocation or eviction, but at other times a move to a different apartment is necessary. The outcomes of these situations can include

resolution of the problem and the consumer remains in the extant apartment, continued clinical work that eventually leads to relocating the consumer to another apartment or a petition for eviction if the problem has repeatedly presented itself with no resolution. Because the housing component and clinical services are geographically (as well as philosophically) separate, the clinical team and the psychiatrist maintain contact with the consumer and can continue to provide uninterrupted services and treatment in any number of circumstances including across a number of apartments, during hospitalization or incarcerations or other interruptions in housing. Given the characteristics of the population served by housing first programs and the harm reduction approach to services, this continuity of services through housing interruptions is one of the most important program components contributing to its success with housing retention.

The clinical characteristics of consumers served by housing first programs are familiar to researchers who study populations that remain chronically homelessness and are frequent users of acute care services: mostly men, mid 40s, very high percentage dually diagnosed, histories of trauma, acute and chronic health problems, criminal justice system involvement, and behaviors often associated with problematic outcomes. Another distinguishing feature is that many consumers served in scatter-site programs are still actively using substances, thus they would be unable to gain admission to congregate sites. Staff in housing first programs must be well trained in the clinical practices related to effective outcomes with this population (motivational interviewing, trauma-informed therapy, harm reduction practice, CBT) and the psychopharmacology of treating people with complex diagnostic profiles.

Harm reduction as practiced in housing first programs requires a practical and creative approach to both clinical work and housing management. Harm reduction is a consumer-directed intervention and gains in treatment are often measured in tiny steps and using highly individualized metrics: for example, went from drinking a six-pack a day to a "40 ouncer" a day; spent fewer days in hospital or jail this year; spent $20 less on drugs this month, etc. The vignette below was selected because it illustrates the often difficult and uneasy resolutions that emerge when working with a deep commitment to a consumer choice and a harm reduction approach. The vignette shows some of the compromises that must be made; compromises that fall somewhere short of the ideal outcomes desired by consumers, clinicians, and housing staff. Hopefully, the decisions described here demonstrate the housing first philosophy: a profound commitment to respecting consumer choice and to providing support services for as long as they are needed.

The case of Ms. S illustrates what can happen if the team has the patience to keep working with a person even through multiple mental health, substance use, housing, and social challenges.

> Ms. S is a 52 year old African American with schizophrenia and alcohol abuse who has had multiple hospitalizations due to non-adherence with medication. She had spent many years homeless and drinking, including a period of time where she lived in the park with other individuals who were homeless. She agreed to an initial evaluation with the psychiatrist but during the evaluation told the psychiatrist she was a doctor herself and that she did not need psychiatric care or medication. She refused to meet with the psychiatrist again and was not engaged with the team. She easily accepted the offer of an apartment and was engaged with the team during the selection, furnishing and move-in period. After that, she spent more and more time in her apartment, deciding one day to resume contact with other people from the park who drank heavily. Soon, they began to visit her in her apartment and she began drinking with them. When the team offered her support and informed her she was under scrutiny by the superintendent she indicated that she had great difficulty telling the people visiting that they could not come and stay in her apartment. They continued to cause disturbances in the building, leading the landlord to call the team with complaints. On several occasions, the team and the psychiatrist attempted to encourage and empower Ms. S to not let these individuals into her apartment and that if she felt she had to see them, to meet them elsewhere in order to keep her housing status safe. The psychiatrist made several home visits and used motivational interviewing techniques to understand her perspective on drinking as well as to suggest several strategies for lessening or changing the context of her drinking. Though

Ms. S said drinking made her feel calmer, her speech and behavior while sober was not always coherent and intermittently she became very agitated. A few days later, during a routine home visit the team observed that Ms. S. had been putting out cigarettes on paper towels and that she had left a burner on the stove lit when not in use. At this point, her behavior was of grave concern and she was involuntarily hospitalized because she presented a danger to herself. After transition from the hospital, the psychiatrist approached her again, but Ms. S. refused formal treatment and medication. The team offered to re-locate her in order to make it more difficult for her previous acquaintances to be present. She readily agreed. The psychiatrist encouraged her to attend at least some groups or drop by the office regularly to avoid being in the apartment and feeling lonely.

Over a period of almost 2 years she remained very symptomatic but at the same time became more engaged with the team in an informal way at the office, including acting as if she was the office manager. Notably, during this time her dangerous self-destructive behaviors did not recur. However, she was eventually re-hospitalized due to an episode of severe agitation and threatening behavior at the office when she did not receive money she thought she was due her. After this hospitalization, she met with the psychiatrist who asked if she would be willing to consider taking medication and Ms. S. indicated she was willing to try. Soon after, she was hired by the organization as a part-time receptionist for team's office.

Rather than presenting clinical vignettes of successful treatment, of which there are many, we chose instead to present a case where we faced difficult situations to illustrate the creativity, long-term commitment, and compromises required to effectively maintain housing and treatment. Like the vignette above, there are numerous situations that can lead to conflicting or problematic interactions between housing and clinical services including: problematic behaviors resulting from nonadherence with medications, substance abuse, hoarding, nonpayment of rent, people squatting in the apartment, inability to maintain the apartment, medical disability, consumer loneliness and vulnerability, and mandated treatments. The purpose of the vignette was to illustrate several of these challenges, highlighting how the team works with consumers in crisis to help them maintain their apartment and their relationships in the building, as opposed to pursing eviction. Techniques such as motivational interviewing are used to further explore why a client chooses not to take medication.

Hopefully, the vignette also demonstrates how for some consumers loneliness can be a significant problem when moving into a scattered-site independent apartment, particularly if consumers have spent much of their life in an institutional setting. When alone in an apartment, symptoms of loneliness can become more noticeable. Consumers often do not know how to spend their time. One coping strategy is to allow family, friends, or even strangers to spend time in their apartment with them. Visitors may stay longer than the consumer intended and take advantage of them. If the visitor then causes problems in the building, then the consumer could be at risk of losing his/her housing. Substance use is often a factor in situations such as these.

Indeed, the vignette demonstrates how clients with prolonged psychiatric disability who have co-occurring substance use disorders encounter obstacles to recovery and housing stability. Consumers may use substances because they like the way they make them feel, because they are attempting to deal with symptoms of psychiatric illness, or because they are around others who are using. Substance use, even alcohol use, is not permitted in most traditional and in congregate housing programs. Thus, relapse often results in expulsion from one's housing program. Yet, there is no evidence that forced sobriety is any more effective in helping people obtain long-term sobriety. In housing first programs, sobriety is not a requirement, but rather a harm reduction model is used. If a consumer quietly uses substances or is drinking in his/her apartment without causing disturbances to others in the building, it is not the first issue to be addressed. The team may be aware of the situation and wait for an opportunity to discuss this issue when it seems it will have the best clinical impact. The team uses motivational interviewing techniques to engage the client in discussion about their use and reduce their use especially if it is a barrier to them achieving their goals. Most often, housing problems that occur due to substance use relate to the consumer bringing others into his/her apartment to use or sell substances which in turn causes noise or traffic problems.

Another problem that may arise is clients not paying rent. Nonpayment of rent can occur for many reasons including paranoia, disorganization, impulsivity, substance use, and just not wanting to pay it. It is important for the clinical team to be aware that nonpayment is happening, but it should not be their responsibility to collect rent. Instead, it is their responsibility to ask clients what the reasons are behind nonpayment, to help them understand the risks of nonpayment, assist them with developing plans to resume payment, and in extreme cases, to apply to be the consumer's representative payee to ensure that rent is paid and the client is not evicted. A representative payee is a legal and contractual agreement that a consumer's SSI check will be sent to the program and the program has the prerogative to manage the consumer's money for the month. Typically, the agency will deduct 30% of the check towards the consumers rent and remit the remainder to the consumer.

Clients engaging in hoarding behaviors after moving into an apartment can also be a very difficult issue to address. Hoarding is a gradual process that becomes increasingly problematic over time. Housing first values consumer choice and initially clinical staff may wish to allow their formally homeless client to have things in their apartment to make it a home and may tolerate a messy apartment because this is how the client is choosing to live. However, there is a point when an apartment becomes unsanitary or unsafe, or hoarding spreads outside of the apartment into common tenant areas, and this cannot be allowed. Clients often find it difficult to make significant changes with respect to hoarding. Clinicians take things step-by-step, helping with clear behavioral interventions such as placing tape on the floor of someone's apartment to mark off areas that need to be kept clear or assisting clients with purchasing storage bins to organize items and remove those that are hazardous.

Finally, as our clients age and develop significant medical problems, medical disability can raise questions about their ability to live on their own. Questions can arise in both terminal illnesses and chronic, poorly controlled illnesses such as diabetes. At the end of life, clients often prefer to have the dignity of spending their remaining time at home. The team, in conjunction with the medical providers, will try to provide in-home services to help the client be able to stay in the home, but at times clients object to these care providers spending significant time in their homes or the care providers do not feel comfortable due to lack of familiarity with mental health problems. If this happens, the team encourages the client to move into a more assisted setting.

A Day in the Life of a Scatter-Site Housing First Psychiatrist

What follows is a sample schedule for a psychiatrist working as part of an ACT team within a housing first program (contributed by William Tucker, MD, Queens ACT team).

8:45–9:15 Supervision with the psychiatric nurse practitioner which involves discussing specific cases and education around psychopharmacology and psychotherapy concepts and practices for consumers

9:15–9:30 Returned phone calls to two consumers who called and left voicemails. Reviewed laboratory results of consumers taken yesterday

9:30–10:30 Morning meeting: reviewed contact log and read progress notes for all 68 consumers, assigned plans for visits, and discussed acute clinical plans:

- We discussed if the team has noticed relapse signs after medications have been decreased for consumer to minimize side effects
- We discussed a consumer transitioning from ACT Team to clinic care who met his new psychiatrist yesterday. The team discussed ways to support him in termination with team and building alliance with new provider

– We discussed a consumer who has improvements in psychosocial outcomes, but struggles with poorly maintained diabetes. The team created specific plans to support her on her physical health wellness through structured visits with support, diabetic teaching calendar, and Nurse and Psychiatrist educated team on checking blood sugar monitoring and management
– We discussed a consumer who after months of motivational interviewing has moved to late preparation stage of leaving family member who has been abusive towards her. We discussed ways to support her guilt in leaving family, clarified her "safety plan" which outlines steps for her safe leaving and logistics of her relocation and transfer
– We discussed a consumer who is undergoing training to be a peer specialist at peer-run center. Many months of psychoeducation and CBT have led him to identify some of his past delusional ideas and hallucinations as a part of a mental health condition which he may modify. He plans on teaching a class on managing voices to his peers at the training center. He agreed to obtain guidance and support on how and when he may disclose his personal experience from the team's peer specialist and assistant team leader
– We discussed a consumer recently hospitalized and the team's effective engagement with her while inpatient. The team discussed our interactions with consumer, inpatient staff, and consumer's family members in order to ensure her hospitalization is as time limited as possible and also clinically effective

10:30–10:45	Walked to consumer's apartment
10:45–11:30	Met face to face with a consumer in his apartment and provided supportive psychotherapy. He formally requested to review his chart to "make sure there is no trauma history." This writer collaboratively reviewed his life narrative, clarified his psychosocial history, and used trauma-informed care approaches to educate on how observing a traumatic incident can affect an individual later in life. The consumer's allopathic medications were lowered and we discussed homeopathic support strategies to support his coping with symptoms
11:30–11:45	Consumer did not keep appointment. I called apartment and family stated he went to detox yesterday. I spoke with family, consumer in hospital, and hospital staff to coordinate detox and rehabilitation plan and to ensure continuity of medications while inpatient. I emailed the team to inform them of communication, contact numbers, and documented notes
11:45–12:15	Completed psychiatric assessment for a housing subsidy application for a consumer
12:15–12:30	Lunch
12:30–1:00	Traveled using subway to consumer's apartment
1:00–1:45	Met with consumer in his apartment diagnosed with dysthymic disorder with comorbid major depressive disorder. He achieved full remission with antidepressant therapy and supportive psychotherapy and has decided to return to school, improve relationship with his son, and no longer is experiencing suicidal ideation and states "I have not felt

	this good in 9 years." He developed side effects of the medications. Shared decision making was used and he chose to lower total dose of antidepressant, augment with a sleep medication, and skew antidepressant to evening dose
1:45–2:00	Walked to consumer's apartment. Received call from the team as a consumer was not receiving adequate mental health evaluation while medically hospitalized at local hospital. I called inpatient staff to advocate for psychiatric evaluation for consumer and to ensure coordination of care if she is discharged
2:00–2:35	Met with consumer in his apartment and provided supportive psychotherapy around bereavement for his wife who died years ago, smoking cessation counseling, and discussed his relapse prevention plan
2:45–3:25	Met with consumer in her apartment and supported her in diabetes management, checked blood glucose, administered insulin, and discussed plans to manage hyperglycemia acutely and long term. Met with boyfriend to coordinate diabetes management plan and provided dietary education to both
3:25–4:00	Traveled back to office, electronically prescribed medications for the day, and identified list of suboxone prescribers for two consumers
4:00–4:35	Drove to consumer's apartment for family meeting. The consumer was working and I met with her mother in her absence. Her mother described improvements in voices, work attendance, and decreased substance use after family therapy and medication changes
4:35–5:00	Traveled home
5:00–6:20	Documented notes and called consumer with elevated blood sugars and confirmed her blood sugar is in control and she is eating diabetic diet

Conclusion

As highlighted in this chapter, there are two dominant approaches to supported housing—a congregate model and a scatter-site housing model. Discussions of these two approaches become complicated once other distinctions are made: permanent vs. transitional housing, housing first scatter-site vs. congregate-supported housing, and on-site vs. off-site services; yet such distinctions have real world consequences for the people served by supported housing and for staff working in these settings. The goal of this chapter was to introduce the reader to the complex issues of providing treatment and housing for individuals being served by the mental health system and illustrate the contribution and rewards of community psychiatrists. In both models described above, the role of a psychiatrist is vital, and although psychiatric services and housing assistance are distinct domains, the need for supportive housing stems from the complex relationship between the two. The vignettes we have presented give indication of the unique challenges and opportunities that come with working in such programs and, by implication, highlight some of the limitations of traditional medical training as a preparation for community psychiatrists.

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30 Fountain House and Community Psychiatry

Alan Doyle

Prior to the 1960s, most people suffering from severe mental illness were housed in state mental hospitals. Although asylums for the insane evolved from a caring, therapeutic approach of the moral treatment,[1] a century later these institutions had become overcrowded, underfunded, and hardly reflective of the humane values upon which they were originally based. With the passage of the Community Mental Health Centers Act of 1963, a new chapter was announced in the care and treatment of people suffering from mental illness; they should be able to live in society like everyone else. Deinstitutionalization was one of the largest social experiments in American history in which close to one-half million people moved out of these institutions and back into their communities. This occurred, however, without sufficient social supports in place, and with even less understanding of the impact that the resulting homelessness, unemployment, and drug addiction would have in the lives of people struggling with mental illness. Furthermore, former patients were expected to live in communities where the stigma associated with mental illness caused them to be viewed with both fear and suspicion. Torrey (1997) has described the result as a psychiatric "Titanic." Others commenting on the current challenges facing community mental health (Rosenberg and Rosenberg 2006) found the current shape of mental health practice as a "fragmented system of care" (p. 3). More pointedly, the President's New Freedom Commission on Mental Health (2003) characterized it as "in disarray" (Executive Summary, p. 4). There are no consistent theories of treatment and the funding system is ill-suited to the demands of those in need. In effect, the goal of deinstitutionalization—namely, that people suffering from mental illness can live and function in society—is a book whose final chapter has yet to be written.

The story of Fountain House, a *working community*[2] for people living with mental illness, relates a different narrative concerning the treatment of the illness. While society relegates those leaving mental hospitals to the periphery, Fountain House welcomes them on West 47th Street to find meaning in their lives and invites them to demonstrate their productive talents in the heart of New York City. Fountain House embodies a fundamental understanding of the destructive nature of mental illness and offers a comprehensive approach to help its members

[1] *Traitement morale*, or the moral treatment, was a psychological treatment for people suffering from mental illness developed by the renowned French physician Philippe Pinel in the late-eighteenth-century. It emphasized therapeutic observations and discussions, and an environment conducive to a humane, caring approach to mental illness.

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[2] The term *working community*™ is used by Fountain House to describe its signature approach to supporting its members in recovery from mental illness.

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regain their lives. It endorsed choice and empowerment for people with mental illness long before they became standard mental health practices. Fountain House has always held employment, decent housing, and (more recently) school success, as the measures of its effectiveness in promoting psychiatric recovery. These inherent ideas have attracted widespread imitation the world over. In effect, Fountain House has always been a pioneer in mental health practice working towards the goal of social integration a decade before the onset of deinstitutionalization.

Its approach to mental health recovery, however, has not been achieved without allies; foremost among them have been community psychiatrists. Fountain House and community psychiatry both came of age during the latter half of the twentieth century. Fountain House and community psychiatry share the same goal of supporting people who suffer from mental illness so that they can live outside the hospital and thrive in their community. Most people are unaware that psychiatrists provided the initial conceptual and programmatic framework of Fountain House. Faculty members of major universities, even an American Psychiatric Association president, served on its Board of Directors and advisory councils. This chapter, therefore, explores the origins of Fountain House, its transformation from a psychiatric treatment (referred to as Activity Group Therapy, AGT) into a normalized, nonmedical approach, the *working community*. This relationship between Fountain House and psychiatry continues today in collaboration with pioneering community psychiatrists (Aquila et al. 1999). As such, it offers a partnership model in integrated health services that holds potential for broad-scale policy and practice improvement in the delivery of community mental health.

The Beginnings

Fountain House was founded in 1948. It grew out of the enterprise of a self-help group of patients that formed in Rockland State Hospital, a state mental institution located in a suburban community just north of New York City. The group had been organized in the early 1940s by Hiram Johnson, a supervising psychiatrist, and Elizabeth Schermerhorn, a volunteer from a prominent, wealthy New York family. Dr. Johnson sought to apply the self-help techniques of Alcoholics Anonymous to patients being discharged from the psychiatric hospital. He envisioned that his ex-patients would assist each other in returning to society (replacing the relationships lost or destroyed by the onset of mental illness with newly found friendships formed in the hospital) and mobilize among themselves to cope with the challenges of hospital discharge, such as in finding housing and jobs.[3] The members of the group called themselves the We Are Not Alone Society, or WANA.

WANA functioned for several years, but soon floundered and disappeared. The importance of the group to people leaving mental institutions, however, was not lost on Michael Obolensky, one of its founders, or on Elizabeth Schermerhorn. In 1948, they reconnected and sought to resurrect WANA as a new organization, the Fountain House Foundation, which provided a structure to sustain the organization and a separately incorporated Fellowship that functioned as a social club for its membership. The purchase of a building on West 47th Street in New York City to house the program cemented the arrangement. The participants named the endeavor "Fountain House" after the fountain that was located in the back patio of their new brownstone.

In this period, Fountain House operated much like a "settlement house" for people with mental illness. It was situated in the community and offered social and educational programs to support its membership after hospitalization. It immediately attracted public attention as a viable framework for helping patients discharged from mental hospitals—so much so that Fountain House formed a Professional Advisory Committee that included Lawrence Kubie, a prominent psychiatrist from Columbia University, and Russell

[3]Mandiberg (2010) notes the importance of such relationships, which are currently overlooked in hospital discharge planning for psychiatric patients.

Blaisdell, the Director of Rockland State Hospital. With their guidance, Fountain House opened a series of occupational training programs which Dr. Kubie characterized as "work conditioning"[4] that would support reentry back into society. In 1949, additional funding from the National Mental Health Act paid for its first professional staff workers.

But the separation of the organization into the Foundation and the Fellowship proved unworkable. By 1955, Fountain House had lost all of its public funding and its staff was resigning. The board, staff, and membership were at odds over who was in charge.[5] It was at this moment that John Beard entered the arena. He had come to New York to present a paper on his work at Wayne County General Hospital (known also as "Eloise") that was located outside of Detroit city. At Eloise, most patients with schizophrenia were considered to have chronic conditions and were never expected to recover. However, Beard made a discovery there that animated the rest of his career.

At Eloise, Beard was wholly taken by the methods of a young psychiatrist, Arthur Pearce. Dr. Pearce and other mental health reformers of the time were appalled by the conditions that people with mental illness housed in the asylums were forced to live in. They observed that, despite their illnesses, these patients were able to work—their patients went out into the fields to pick vegetables and they staffed hospital laundry rooms and kitchens. Recovery from mental illness then was a real possibility. They hypothesized that normal group activities done on the ward would support patient recovery, which they referred to as rehabilitation. Accordingly, Beard introduced ordinary activities such as painting, woodworking, play acting, mathematics lessons, and even popcorn-making onto the ward. Pearce and his team found that even though most of the patients were very withdrawn, they were still eager to engage in these activities. This perceptible change in the patients compelled the attendants and nurses to alter their attitudes; they saw their patients as capable. And the patients, in turn, felt better about themselves.

Pearce and his colleagues were clearly influenced in their thinking by the innovative practice of *milieu therapy* that was popular at the time. Milieu therapy held that people in the environment—the hospital attendant staff and even the fellow patients—could be enlisted to contribute to the recovery of people with mental illness.[6] The team wanted to demonstrate that what they called Activity Group Therapy could be applied to even the most withdrawn patients who rarely, if ever, left the ward. By linking the attendant staff and even the other patients together in normal human activities on the ward, the team found that such group efforts were constructive, empowering, and ultimately transformative. They concluded that participation in AGT resulted in varying degrees of patient improvement and broadly summarized their success in a paper (Beard et al. 1958) noting that "the patient's new experience in participation with others on a basic reality level seems to promote a process of reinstituting lost ego capacities; and that 'AGT' can play an important part in facilitating adjustment in the community, thereby potentially lessening the probability of re-hospitalization" (p. 136).

At Eloise, Beard learned from Pearce that, despite their mental illness, patients still possessed within themselves the resiliency to take control of their lives; that participation in ordinary human endeavors contributed to their recovery; and that staff played a crucial role in the recovery process. These insights acquired amidst the desolate conditions of a custodial mental hospital ward in 1950–1951 accompanied Beard for the rest of his professional career and resulted in his recasting of the foundations of Fountain House.

[4]May 3, 1949 minutes of the Professional Advisory Committee, Fountain House, New York.

[5]This episode is explored in Anderson's (1998) history of Fountain House *We Are Not Alone*. It is of note that the same dichotomy exists today over who should be in charge of recovery in mental illness—the patient or the professional. John Beard resolved this conflict in a manner that empowered both the patients and the professionals in a collaborative process.

[6]A similar movement was taking place in England with the *therapeutic community* of Jones (1953) that involved the entire hospital community in contributing to the recovery process.

Reshaping Fountain House

From the moment Beard first set eyes on Fountain House, he was taken with its potential. He knew from the experiences with his patients at Eloise that an impoverished setting and disregard for basic human decency in mental hospitals contributed adversely to their illnesses. To him, Fountain House sat vacant and could be molded to his own liking. With the change of venue from a hospital to an urban setting, Beard saw the potential for creating the type of positive social interaction that was reflected in the principles of AGT. Then an initiative by Mary Smith, a social worker at Fountain House, gave him a fresh way to think about how to use the vacant space.

Beard recounted (1978) that one day Mary Smith started preparing lunch in the downstairs kitchen at Fountain House and invited members to join her. The tasks of making lunch and cleaning up afterwards constituted a basis for AGT. They were activities in which individuals suffering from mental illness could participate and make a contribution—addressing the immediate needs of others for a daily meal—and for which they could find personal meaning and accomplishment. While not denying their illness, Beard believed (as have most practitioners in mental health) that patients who engaged in everyday activities felt better and were able to move on with their lives. Susan Omansky, a member of Fountain House, clarified this impact of Fountain House in her life saying, "I also needed to engage in something from which I can derive my own sense of pride, accomplishment, and self-satisfaction" (Quoted in Waters 1992, p. 42). Beard concluded that the framework of a workday organized around such activities as preparing food, answering the phone, or helping other members with their housing would be the organizational scaffolding around which the members and staff at Fountain House would daily join together. As there is nothing unusual about going to work, the expectation for members would be the same as everyone else in society; they could be counted on to show up for work at least five times a week. Thus, the day program (as it was referred to at the time) would feature work as its programmatic center. Work at Fountain House became a therapeutic, yet nonmedical, application of group activities that supported member recovery. It provides as well the rationale for referring to Fountain House as a "working" community.

Today, Fountain House differs from its inception mainly in size and diversity, and not in its central themes and purpose. The house conveys an attractive appearance to anyone entering its front doors with a grand staircase, wood-paneled walls, and a tasteful living room. Its appearance is deliberately contrived to challenge the expectations most people envisage upon entering a mental health setting.

The activities of the house are organized around a normal 9-to-5 work day with an after-hours program in the evenings and on weekends and holidays. During weekdays, members and staff collaborate on activities that are needed to support members in psychiatric recovery. Various work activities are organized into groups, called "units." Some units directly address the interests of members in returning to society through education, employment, wellness, and housing. Other units sustain the operation of the *working community* providing member intake and orientation, dining, research, and horticulture. Fountain House also incorporates members into its accounting, fundraising, technology and human resources offices, and sponsors special in-house projects devoted to members who are deaf and who are young adults.[7]

The formation of Fountain House as a place of work also gives definition to the major roles of members, staff, and others who work there. While operating within a framework based on work, Fountain House does not reflect the specialized division of labor that typifies most contemporary businesses in general and mental health agencies in particular. Instead, two simple, highly-flexible functional categories of member and staff worker constitute its major division of

[7]Additionally, Fountain House operates an international training institute, a professional art gallery for member artists to sell their paintings, and a rural farm in northern New Jersey.

labor. Members and staff are expected to work together, "side-by-side," in the daily routines of the house. In effect, the membership shares with staff the responsibility for its smooth running. While member participation in the tasks or activities at hand is essential, members are free to choose how they will participate. Staff are expected to reach out and support member involvement by structuring the environment with opportunities for meaningful involvement, supporting members in taking risks, and recognizing their achievements when they succeed.

Other roles at Fountain House include the Executive Director, who holds the ultimate responsibility for all community operations, and the Board of Directors, who exercise fiduciary responsibility and provide access to broader resources in the community to ensure the organization's long-term sustainability. Finally, as a social agency deeply committed to the health and welfare of its members, as well as to people suffering from the stigma of mental illness worldwide, Fountain House attracts numerous individuals who volunteer their time to work within its community or provide financial support as donors. Today, Fountain House has become a large social service agency with approximately 1,200 active members annually and over 70 staff workers.[8]

Employment in regular jobs has always been the ultimate goal for Fountain House members. Initially, Beard found that for many Fountain House members personal capacity development was not enough. With long hospitalizations, no recent job experience, and riven by insecurities, members were afraid to go out on a job. Something more was needed. If eventual employment was to be an outcome for its members, Fountain House had to break through the barriers that the membership faced in gaining employment. Beard, borrowing from his earlier practice at Eloise in securing employment for his patients with local businesses, again tapped into the vast potential of local commercial establishments in New York City for support in the vocational development of the membership. The resulting program, *transitional employment*,[9] was started in 1958. Today, Fountain House offers a full range of employment options including supported and independent employment, and recently, experiments in member-owned cooperatives. At any one time, 35% of the membership holds positions of paid employment. Success in employment at Fountain House is an assault on stigma in the workplace and represents an ongoing testament to the capabilities of members to hold down competitive employment despite their illness.

In a similar fashion, Fountain House early on began assisting members with another crucial aspect of life—housing. Beard was keenly aware of how living alone in hotels exacerbated the isolation of those suffering from mental illness. Fountain House responded by expanding into the housing market. Representatives of the organization negotiated with landlords and signed leases to apartments in various locations around the city. Today, Fountain House provides a residence to over 500 of its members.

By 1960, under John Beard's leadership, the essential framework of Fountain House was well-established through its workday and after-hours programs and its inroads into the larger society via employment and housing (which have since been expanded to include supported education). Each component was integral to the others within the context of a *working community* setting. In 1965, Fountain House moved into its current location across the street from the original building.

Foundation Principles of a Working Community

While Fountain House was intentionally built around the cultural construct of a workplace, it is not a conventional workplace. It does not manufacture or market a product for consumption by

[8]Figures do not include the number of staff separately employed in the Fountain House housing program.

[9]Transitional employment was an innovation wherein Fountain House partnered with employers in establishing a temporary position for its members to test out their abilities and establish a work history.

the general public. Fountain House has established itself as *working community* intent upon the recovery of its members suffering from mental illness. In this respect, Fountain House views the dissolution of personal and professional relationships that normally accompany the illness—Beard referred to it as "relationship deficit" (Beard et al. 1958)—and social isolation as the aspects of the illness demanding his attention. A *working community* is a place where members can engage in meaningful activities and regain their sense of self and sense of community (Sarason 1974); it is the treatment that counteracts social isolation. With staff and members as partners in the process, Fountain House recreates a social ecology supportive of member recovery (Doyle et al. in press).

Several key principles operationalize such an outcome. Fountain House features a normalized work environment in which the need for member participation (the *need to be needed*) becomes the catalyst that operationalizes the collaborative nature of the endeavor and empowers its members to participate in their own recoveries. At the same time, Fountain House is wholly built upon member choice and creates a concrete setting wherein the fundamental insights of such theorists as Deci and Ryan (1985) into the power of personal choice in fostering self-identity and self-actualization are substantiated. As Deci & Flaste (1995) has described:

> The main thing about choice is that it engenders willingness. It encourages people to fully endorse what they are doing; pulls them into the activity and allows them to feel a greater sense of volition; it decreases their alienation (p. 34).

In effect, Fountain House shifts the focus of treatment of those with mental illness from patient pathologies to the clients themselves as agentic individuals. Finally, Fountain House calls for a shift in the power arrangements between the professionals and their clients and requires those with power to join on an equal footing, *side-by-side*, with those who are systemically denied such status. It expects mental health staff workers who are accustomed to working arrangements based on hierarchy and specialization to shift to a framework based on mutuality and collaboration. In this respect, as a *working community* in which recovery is the result of normalized staff and member relationships, Fountain House offers an appealing professional alternative to the ideal currently promoted in society and in the universities that prepare its mental health professional class.

The *need to be needed*, *choice in* all matters, and the *collaborative nature* of the staff role are the principles that give Fountain House its programmatic identity as well as its therapeutic punch. In effect, Fountain House has become a wholly secularized version of what Beard originally tried to achieve in the therapeutic application of group activities at Eloise. Stripped of its medical surroundings and its preoccupation with illness, the workday at Fountain House provides an ordinary setting for social interaction and personal contributions in which the collaboration of staff and members in everyday activities becomes a transformative event and holds out the promise of aiding in mental health recovery.

Replicating Fountain House

Fountain House, conceived as a place of work, was the essence of Beard's approach to advocacy in mental health. It held a powerful demonstrative payoff and presented a visible statement of the inherent worth and health of people suffering from mental illness. If the members of Fountain House were perceived as doing normal things, then society would be forced to acknowledge that they just were not as sick as they were deemed to be. By its very existence, Fountain House would challenge the prejudices associated with mental illness and demand a reevaluation of how people with mental illness were perceived and treated.

But a demonstration approach to widespread diffusion proved insufficient. Despite its national reputation and hundreds of visitors annually, Fountain House remained practically alone in its way of working (only a handful places modeled after its design were started by former employees). So in 1977, Beard responded to a proposal from the National Institute of Mental Health (NIMH) to develop a training program to improve

the lives of the mentally ill in the community. Thus began what became at the time the most successful training effort ever underwritten by NIMH (Propst 1997). Eventually, international conferences were initiated and additional training bases were established to support the expansion. The diffusion of the model entered into a new phase in 1987 with the creation of a Faculty to provide onsite peer support and the formation of a set of Standards (1990) that codified the practice of the model. Finally, Fountain House, in concert with clubhouses throughout the world, formed the International Center for Clubhouse Development (ICCD) to assume responsibility for building and coordinating a network of programs modeled after its innovative insights. Within 20 years of the initial training grant, over 300 programs claiming to follow the Fountain House philosophy had been established throughout the globe.

Still, the efforts of Fountain House and its associates compared to the enormity of the task at hand seem marginal at best. Despite deinstitutionalization and the recovery paradigm that followed it—that people with mental illness can lead normal and meaningful lives in society (Anthony 1993), full social inclusion has yet to be attained. Too many continue to live in isolation in society. Employment, which should be a criterion of success, still represents a major barrier to social integration with unemployment running seven to eight times higher among people suffering from severe mental illness than the rest of the population (Mechanic et al. 2002; Milazzo-Sayre et al. 2001). In an ironic twist, a study from England reported that unemployment among people suffering from severe mental illness had increased since deinstitutionalization (Marwaha and Johnson 2004).

Furthermore, contrary to what many people think, most federal mental health dollars today are still paying for hospital services (Milazzo-Sayre et al. 2001); general hospitals use funding usually under Medicaid to fill their beds in psychiatric wards. There exist no financial incentives for these general hospitals to share their mental health dollars and support integrated community care. Thus, funding for mental health represents a bifurcated system in which community general hospitals serving those with serious mental illnesses operate at the expense of most community treatment programs. The problem is further exacerbated by the fact that patients must travel to a variety of agencies in order to get the help they need, and all too often, get lost in the process.

Existing Models of Community Support

Available treatments are limited as well. The vast majority of people suffering from some form of severe mental illness meet with their psychiatrist only once a month, primarily to review their medication. This state of affairs is no different from the concerns of 35 years ago, when a federal report called for improvements in community-based supports for people discharged from mental hospitals (General Accounting Office 1977). Despite the intervening decades, society offers only limited support in managing the illness to those living outside of a mental health hospital.

Community support services that do exist, for the most part, take the form of case management. Case management (Rubin 1991) is a "boundary-spanning" approach that utilizes an individual who monitors and supports his or her clients in the community. It seeks to link "the client to the maze of direct service providers" (p. 5). The nature and extent of their professional responsibilities vary widely, but they usually consist of a package of benefits including counseling, linkage to housing, medical and psychiatric services, and in more recent times, vocational specialists. The assumption throughout is that once the specialized professional treatments have been administered (e.g., supported employment or access to housing), there exist a variety of nonmental health "natural resources" in the larger community which are relatively welcoming (i.e., stigma free) and readily accessible. Such an approach to the delivery of rehabilitation services is considered to be characteristically American in design. As Lamb (1994) has noted in comparing U.S. and British mental health community support systems: "Americans emphasize skills acquisition

and the importance of a skill-based approach in helping people function as independent as possible with the minimum of support" (p. 1019). Fountain House in contrast represents an approach where community support systems focus more on environmental supports, an approach that is more typical in the United Kingdom.

Peer support programs provide another popular recovery treatment model. These programs sponsor various self-help programs in community resource centers, attempting to create supportive social networks among their own which provide day activities, counseling, medication support, and transportation, among other services (Chamberlin et al. 1993). It is not surprising that, while some professionals have difficulty understanding the need for peer support systems, consumers and family members instinctually understand that people suffering from mental illness need a community of support and that they like to be with those who share similar issues. Fountain House shares the social support and empowerment goals of the self-help and consumer models. Indeed, a number of Fountain House members have found employment as peer counselors in these endeavors. Fountain House, however, differs with those within the consumer movement who are "separatists" in approach (Chamberlin 1978; Borkman 1999) and advocate an exclusively consumer-run approach that does not allow for a clear role for professionals in the delivery of mental health services. If we cannot find people drawn to the mental health profession who can work without prejudice, what hope do we have for being successful with society at large?

Actually, Fountain House combines aspects of both the case management and self-help models in psychiatric rehabilitation services. Fountain House offers choice to people who are regularly denied it and thus represents an empowerment mode typical of the consumer movement. It features a clear professional role of a social practitioner (albeit different from the specialist service approach provided through case management described above) that fuses staff collaboration with member empowerment in creating a *working community*. Most importantly, Fountain House combats the fragmentation in rehabilitative services that has resulted from deinstitutionalization by providing a social framework within which all the services needed that directly address the major stumbling blocks to success in deinstitutionalization—homelessness, unemployment, and school failure—can be found in one place.

Considering the numbers of individuals currently untouched by social service systems, in looking to the future Fountain House suggests a different approach be tried than is currently popular. There needs to be a common *place* where people living with mental illness can overcome their sense of isolation and find the resources they need within a community of support in recovery. Recognition for such an approach has been publicly acknowledged with the announcement by the federal Substance Abuse and Mental Health Services Administration that the Fountain House approach has been listed in the National Registry of Evidenced-based Programs and Practices,[10] indicating that its outcomes are supported with quality research and that the approach can be readily disseminated in other contexts.

Partnership with Psychiatry

Over the past 15 years, Fountain House has been experimenting with a version of the *health home* concept[11] that partners its *working community* approach with a nearby medical clinic that integrates psychiatric and primary care founded by the St. Luke's and Roosevelt Hospitals (Aquila et al. 1999) (for details on primary care—behavioral health integration see Chap. 14). Each component of the partnership, the medical and the community supports, is housed and operated separately in accordance with their own practice dictates. But the communication among the

[10] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189. The generic term "ICCD Clubhouse," with Fountain House as its originator, is the actual listing to reflect the partnership of many strong clubhouses in the United States and around the world in achieving this goal.

[11] Now featured in Section 2703 of Public Law 111-148, the Affordable Care Act of 2010.

partners results in an amalgam that is designed to serve people with mental illness on a long-term basis: the team as a whole sees the goals of employment, wellness, housing, and education as mutually supportive and vital to the long-term health and recovery of the member. In most instances, for example, Fountain House social workers who spend considerable time with members on a daily basis are in a unique position to provide insight to the doctors about members' conditions. The partnership also demonstrates how respect for member choice makes this combination of primary medical and psychiatric care and recovery possible. The members become directive of these efforts. At their discretion, members invite the staff worker from the clubhouse or residence to accompany them to the storefront clinic. Thus, the medical, psychiatric, and social work staff all become attuned to the subtlety of an individual's recovery process and the importance of choice and collaboration in the process.

Additionally, as it can be difficult to attract psychiatrists and general practitioners to work with people with major mental illnesses in the community, Fountain House has created a satisfying job for the psychiatrist that facilitates long-term relationships between doctors and patients with an emphasis on rehabilitation and recovery. Each of its physicians is able to spend more time with his or her patients and is attuned to their recovery goals (such as the attainment of jobs, school, or housing) as well as to their physical and mental health. The extra time allotted to the psychiatrist in working with the member and staff person ensures that there are no confounding factors to impede progress. Its storefront psychiatrists and primary care physicians have, in effect, a different kind of healthcare practice—one that resembles the old-fashioned general practitioner whose knowledge of his patients' lives informs their treatments, or in Fountain House's case, their recovery process. Consequently, this alliance has resulted in the timely detection and treatment of major medical conditions, such as diabetes and heart disease, and in a yearly rehospitalization rate of less than 3%. Upon visiting the opening of its new Sidney Baer Center located on West 37th Street in New York City, the New York State Health Commissioner announced that it represented "the leading edge of innovation in serving and meeting the needs" (Shah 2011) of people with severe mental illness.

Summary

Fountain House began before the advent of psychopharmacology with a belief in the fundamental resiliency of the human spirit. It continues to operate under this belief. At Fountain House, recovery means that a person with a mental illness can live in a permanent home, find a job, and enjoy friends. The hope, self-efficacy, empowerment, and supportive relationships that define our recovery-oriented approach are all integrated into the *working community* approach originated by Fountain House.

It is inconceivable that Fountain House would have ever achieved the framework of a *working community* without the therapeutic pioneers who inspired its constituent structures. Fountain House represents the application of peer support principles of Hiram Johnson at Rockland State Hospital and the secular innovation of milieu therapy of Arthur Pearce of Wayne County General Hospital. It expresses in practice the person-centered, strengths-based approaches of modern architects of positive psychology such as Rogers and Maslow and prefigured by decades the critical importance of self-determination theory of Deci in a recovery paradigm. It was the genius of John Beard, however, that translated these therapeutic approaches into a framework that can be easily embedded in the workings of everyday society. And, even more exciting, this partnership between community psychiatry and Fountain House continues now and offers hope to people living with severe and chronic mental illness. *Working communities* modeled after Fountain House in association with an integrated medical health facility offer comprehensive community psychiatric recovery centers. As such, Fountain House delivers daily on the goal of deinstitutionalization and proves that people living with severe mental illness can live and thrive in our society.

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Innovative Community-Based Crisis and Emergency Services

31

Deepika Sabnis and Rachel Lipson Glick

Introduction

In order to appreciate the development of crisis and emergency care in psychiatry in its present form and the potential for innovations in the future, it is important to understand the evolution of psychiatric care in general. Individuals with mental illness have remained on the margins of society throughout our history. They have been subjected to various forms of mistreatment in many periods, both in community settings and in the asylum or state hospital systems. In the mid-nineteenth century, Dorothea Dix advocated for the humane treatment of the mentally ill, specifically requesting the creation of institutions that would "provide structure, security, and a healing environment" (Casher and Bess 2010) (see Chaps. 2 and 5 for details). By the late 1800s and early 1900s, many asylums were operated on the theory that moral approaches to care, characterized by staff and family support, productive activities, and a pleasant environment, was the proper way to treat insanity, and some of these ideas are reemerging today.

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While this moral treatment model was a bright spot in the era of institutional care, the care of those with mental illness also included many attempts to "cure" with methods such as hydrotherapy, insulin coma therapy, ECT, and frontal lobotomy, which had no evidentiary basis and were often seen as punitive and controlling measures. These perceived abuses in conjunction with hospital overcrowding and the high expense of maintaining hospital facilities lead to efforts to move care for persons with mental illness back to the community. This transition toward community living necessitated the development of the crisis and emergency treatment models described in this chapter.

The Community Mental Health Center (CMHC) Act of 1963 created community mental health centers that were intended to serve persons with severe mental illness in the community. It mandated that CMHCs provide 24-h psychiatric care (Berlin and Fishkind 2008). Unfortunately, the services offered by fledgling CMHCs did not prevent readmission of deinstitutionalized patients because the centers lacked the means and resources to respond to acute exacerbations of illness. So the CMHC Bill of 1975 provided funding for crisis stabilization, intensive case management, outreach services, and supportive housing to aid with the transition from institutionalization (Berlin and Fishkind 2008). With the ever-dwindling availability of hospital-based care, these services have become increasingly important. As psychiatric emergency services incorporated pharmacologic treatment advances

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and developed supportive and preventive services such as phone hotlines to reduce suicide, they were better able to meet the needs of community living (Allen et al. 2002). In this chapter, we focus on three types of programs that were developed to help maintain people with mental illness in the community: mobile crisis teams (MCTs), psychiatric emergency services (PESs), and crisis residential facilities (CRFs).

MCTs emerged in the late 1960s and early 1970s. They were created to serve individuals experiencing a psychological crisis that crippled their usual coping skills (Gillig 1995) and they evolved into programs using multidisciplinary teams to treat persons in crisis in community settings. They are often attached to hospital or community-based mental health services.

PESs are specialized emergency services designed to treat patients in acute crisis or emergency situations. They are usually located in urban settings within large medical centers that treat a high volume of people who present with psychiatric disorders. While they attempt to stabilize patients and return them to the community with additional support and continuing care, they also often serve as the gatekeeper for inpatient psychiatric services (Berlin and Fishkind 2008).

CRFs initially served as an alternative for patients being released from the hospital who did not have a safe or structured environment post-discharge, but now also play a role in hospital diversion efforts. A number of innovative crisis residential programs arose in the United States and Canada in the 1970s and 1980s to address the needs created by diminishing inpatient beds and skyrocketing hospital costs. By providing flexible, person-centered treatment on a short-term basis in a less stigmatizing, home-like setting, CRFs served to stabilize patients and facilitate their reentry into the community (Greenfield et al. 2008).

Individuals seeking help during a crisis need access to a variety of community resources and adequate support to experience a sense of control and empowerment. Ideally, crisis intervention services should be well integrated and exist in the context of the larger behavioral healthcare system as well as community as a whole. In the remainder of this chapter, we describe MCTs, PES, and CRTs in more detail and then consider their place in the design of comprehensive and integrative systems of care for persons in crisis.

Mobile Crisis Teams

While there are many variations, MCTs consist of multidisciplinary teams that include psychiatrists, nurses, psychologists, social workers, peer counselors, and in some cases, psychiatric residents and medical students (Zealberg et al. 1993). These crisis intervention teams provide immediate assessment in the community setting followed by implementation of treatment, which generally involves counseling, medication, increased support, or a combination of these strategies.

MCTs deliver a spectrum of clinical services in the community with the idea that direct response to a person in a familiar environment allows for a more accurate evaluation of his or her symptoms, functional status, and support system (Alexander and Zealberg 1999). MCTs have three primary goals: provide crisis services in a natural environment, bring services to patients who would otherwise be difficult to reach, and decrease hospitalization via treatment resources and environmental supports (Gillig 1995). Currently, there are a variety of crisis units in practice and their expansion nationally and internationally has been dramatic. In fact, in North America and Australia, these units serve as the primary treatment modality in some rural community mental health programs (Joy et al. 2008).

Mobile crisis outreach services currently in operation in the United States fall into three categories from highest to lowest acuity: emergency teams, urgent teams, and MCTs (Allen et al. 2002). *Emergency teams* operate around the clock and work directly with or within psychiatric emergency departments, police departments, and emergency medical services, usually to facilitate psychiatric evaluation, sometimes leading to inpatient admission. *Urgent* teams see people in the naturalistic community settings or on a scheduled basis in a clinics and initiate treatment in

conjunction with an individual's social supports, whether family, residential staff, or community networks. They seek to avert hospitalization, but when a person's needs become more acute or there is a concern for safety, they often refer them to the emergency department or PES. Finally, *mobile crisis units* often serve as offshoots of outpatient clinics, providing brief, targeted, family-centered treatment in the community. All mobile crisis outreach services work to bolster natural supports and coping mechanisms, thus preventing inpatient admissions for both adults and children (Gillig 1995).

Individuals and families served by MCTs are vast and varied from a geographic, demographic, socioeconomic, and clinical standpoint. To name a few, they include urban, suburban, and rural populations, the elderly, homeless, minority, groups, and persons with co-occurring mental illnesses and chemical dependency. Crisis teams typically see people who lack insight into their mental illness, refuse treatment, and have significant functional impairment to the point that they cannot seek treatment on their own, or who lack access to treatment due to transportation difficulties or economic limitations. In addition, MCTs serve as a conduit to public and private community mental health resources and thus receive referrals from agencies, clinics, and the police department, not just family members or others close to the person in crisis (Zealberg et al. 1993). They may deal with cases that other providers cannot handle, not only helping the patient but also providing guidance and reassurance to the person or agency that made the referral. In these scenarios, MCTs serve as advocates and educate community members about the needs of the mentally ill and available resources.

While MCTs have a number of benefits, there are drawbacks as well. As with all emergency services, there can be significant daily or monthly fluctuations in the number of individuals needing care, creating challenges in using time and resources efficiently (Alexander and Zealberg 1999). The heterogeneous nature of these teams has made it difficult to establish standards of care and there are very few rigorous studies to determine efficacy and outcomes of implementation of a MCT (Geller et al. 1995). The data that are available suggest that MCTs can reduce hospital admissions by up to 50%, retain more patients in treatment, and decrease the stigma and burden for both consumers and families (Joy et al. 2008).

One study done in Cuyahoga County in 1996, when the Ohio county shifted from a hospital-based to a community-based PES, found that consumers who used the hospital-based service were 50% more likely to be admitted than those who were engaged by the mobile crisis service, which included a hotline, an MCT, and the authority to authorize inpatient admissions (Guo et al. 2001). Even though there is little data on the cost-effectiveness of MCTs, evidence does suggest that they save money when compared to hospital care (Guo et al. 2001). There are no random trials comparing crisis intervention with hospital care.

Another study done in 2000 looked at the mobile crisis program of DeKalb County, Georgia, which was implemented in 1993 as a joint venture with the county's public safety department. Its goals were to stabilize persons experiencing psychiatric crisis, decrease arrests of mentally ill individuals in crisis, and reduce the amount of time police officers spend handling psychiatric emergency situations. A team consisting of four police officers and two psychiatric nurses (with a psychiatrist available for telephone consultation) provided the initial response to 911 calls identified as psychiatric emergencies either via phone or in the field. They also screened calls from the crisis hotline of the local CMHC and provided follow-up over the phone or home visits. An evaluation of this program measured program effectiveness by comparing differences between the hospitalization rates of the study group and found that 55% of cases handled by the MCTs were managed without psychiatric hospitalization (vs. 28% with police intervention alone), a statistically significant difference. Furthermore, the average cost of the MCT and police intervention was far less ($455 and $75, respectively) than for inpatient admission (over $1,000), demonstrating a sizable cost savings for DeKalb County (Scott 2000).

A study by Bengelsdorf et al. in 1993 showed that a crisis intervention service, while initially

expensive to implement, produced a savings of nearly $100,000 by diverting inpatient admissions (Bengelsdorf et al. 1993). However, it is worth noting that while this MCT had a goal of providing treatment in the least restrictive setting, they still hospitalized nearly 1/3 of those individuals seen on the first visit, demonstrating that despite the emphasis on less expensive and less restrictive levels of care, there are instances when these objectives must be set aside in order to provide care at a level appropriate to individual clinical circumstance. Overall, it appears that mobile crisis programs are a cost-effective component of a mental healthcare system, but standardization and further evaluation of the costs and benefits is needed.

Psychiatric Emergency Services

The comprehensive PES is a relatively new entity in mental health care and its creation was shaped by political, social, and economic factors. Prior to the advent of the modern PES, general emergency rooms of large, urban hospitals experienced an overflow of psychiatric patients and would assign psychiatry residents to see them. In the 1930s and 1940s, "after-care" services emerged as adjuncts to psychiatric hospitals. These units served recently discharged patients who were having difficulty adjusting to posthospital life. Thus, they provided a way to handle former inpatients not sick enough to be admitted yet not well enough to live independently (Wellin et al. 1987).

From 1992 to 2001, there were 53 million mental health visits to general emergency departments (EDs), representing a 4.9–6.3% increase over the prior decade (Boudreaux et al. 2009). In 1955, of the 1.7 million individuals in psychiatric treatment, 77% were inpatient. Forty years later, in 1994, the number of individuals receiving psychiatric treatment in EDs increased nearly tenfold to ten million, but those in inpatient treatment dropped to 26% (Allen et al. 2002).

In 1978, the first American Psychiatric Association (APA) task force on PESs endorsed a "triage model" consisting of "rapid evaluation, containment, and referral" as proposed by Gerson and Bassuk. By definition, a psychiatric emergency involves an acute disturbance in mood, behavior, or relationships that could potentially become or has become catastrophic due to lack of resources or supports. The role of PES is to compensate for the mismatch in needs and resources, determine whether the situation is urgent vs. emergent, and offer treatment accordingly (Allen et al. 2002). In 2002, 25 years after the first PES task force, the APA revised the description of PESs to include not only the triage function but also a "treatment model," which consisted of comprehensive assessment and referral to a broader range of services. While the scope of PES has expanded, its primary function remains the rapid assessment, treatment, and referral of patients in acute psychiatric crisis to the appropriate level of care (Allen et al. 2002).

Patients arrive at PES in a number of ways: via ambulance following a 911 call to the police or EMS, referral by an outpatient provider, agency, or family member, as a transfer from the Medical ER, or on their own (Allen et al. 2002). The following are the most common clinical presentations in PES: people who are acutely suicidal (40% of visits) or homicidal, grossly psychotic, intoxicated or in withdrawal, agitated, and children with behavioral disturbances (Allen et al. 2002). Less emergently, there are those who are dealing with the psychological aftereffects of an acute stressor such as trauma or a loss, have run out of their medication, or urgently need psychiatric referrals. There are also more rare, serendipitous instances in which people are brought in by friends and family members for physical complaints, but on assessment, an underlying psychosis, mood, anxiety, or other disorder is revealed. Finally, there are jail diversion cases in which individuals in custody are deemed by law enforcement to be "emotionally disturbed" or at risk of suicide are brought to PES for psychiatric evaluation and treatment.

Emergency services do not exist in isolation from the systems and populations they serve, so the components of a modern PES must be linked, coordinated, and flexible. Structurally, a relatively quiet, safe, and contained area with a

spacious waiting area and interview rooms is needed. Ideally, the layout should enable staff to easily monitor patients while maintaining their privacy. If direct observation is not possible, the use of closed-circuit video monitoring is an option (Byatt and Glick 2008).

For patients who are agitated or dangerous, the least restrictive interventions are preferable. Immediate assessment by staff is required and security personnel should be alerted. Verbal de-escalation, support, and in many cases, the judicious offer of oral medication should be first-line interventions. If a person remains immanently dangerous to himself or others, use of a locked seclusion room, possibly with the use of restraints and injectable medication, may be required for safety, but this should be considered only as a last resort (Byatt and Glick 2008).

When necessary, people who require seclusion and restraint should be cared for in areas separate from the consultation rooms and waiting areas. These individuals should be monitored one-on-one by PES staff members. While necessary and useful, seclusion and restraint pose a risk to both patients and staff and it is critical to minimize its use. To accomplish this, a change in PES culture may be needed. Significant investment in staff training and support from administration may be required (Byatt and Glick 2008).

PESs should have collaborative relationships with a medical ED, inpatient psychiatric units, and consult/liaison teams (Berlin and Fishkind 2008). Ideally, a short-term observation unit (24–72 h) should be available for individuals who may require longer stays in order to stabilize, but who do not require inpatient care. Occasionally, these units may be used for people who are awaiting inpatient admission. Most psychiatric emergency rooms also have 24-h crisis phone lines (Allen et al. 2002). PESs should have linkages to mobile crisis services (see previous section), crisis residential services (see next section), mental health clinics, law enforcement, schools, local shelters and housing agencies, substance use treatment centers, college mental health services, and others agencies that can potentially provide support to individuals and their families in crisis (Berlin and Fishkind 2008).

From a staffing perspective, PES personnel should include psychiatrists, licensed, and master's level social workers and/or psychologists, nurses, and support staff, including medical assistants (preferably with some psychiatric training) and clerical staff (Berlin and Fishkind 2008). Trainees, such as psychiatry residents and medical, social work, and nursing students, often rotate in PES associated with academic centers because they are ideal settings for teaching rapid assessment, diagnostic, and treatment strategies. Challenges to staffing include lack of funding and/or personnel, adequate staff training, treatment team cohesion, and the development of an around-the-clock shift schedule. By its very nature, the volume of patients seen in an emergency department is unpredictable. Many psychiatric emergencies present after hours, when outpatient treatment centers are closed and other resources or supports are not available. PES should have access to flexible staffing in the evenings and/or weekends to accommodate these peaks in flow and increased acuity levels (Berlin and Fishkind 2008).

A major criticism of PES is the wide variability in services offered and poorly defined standards of care, leading to variation in the information obtained during assessments. One reason for the lack of adequate standards of care is the disagreement about what types of treatment should be offered (Allen et al. 2002). This is usually affected by reimbursement arrangements and rates. Given the current economic climate, many people are uninsured or underinsured and use the emergency department as an outpatient clinic. Also, many private insurance plans, particularly those using restrictive managed care, have limited mental health benefits and when those are depleted, PES fills in the gaps. Under the Emergency Medical Treatment and Labor Act (EMTALA), emergency services must provide screening and stabilization for any person presenting to the ER. However, in today's cost-containment environment, PES must come up with creative solutions to prevent overuse of expensive treatments such as hospitalization (Berlin and Fishkind 2008). Ancillary services such as MCTs, extended observation units, and crisis residential

services can prove useful in these cases. Another option is to provide interim care or "bridging" appointments in PES for those patients who require urgent follow-up until seen by an outpatient provider.

As a first access point for people who are in crisis, the PES acts as a gatekeeper for access to community-based mental health services as well as more intensive and restrictive services such as hospitalization. The limited research on PES suggests several areas for development: cost-effective allocation of resources, service innovation, and refinement of assessment tools (Brown 2005). But despite its limitations, PES continues to adapt and evolve to meet the needs of an overburdened mental healthcare system, and until comprehensive community support services are fully implemented, demand for its services will continue to increase.

Crisis Residential Facilities

Safe, therapeutic, and recovery-oriented placement options in the community for people with psychiatric disorders have become a significant need, particularly as the number of acute inpatient and long-term psychiatric beds has diminished, with a resultant increase in pressure to use resources wisely. Nearly half (43%) of mental health resources are spent on care for patients with severe mental illness, with the greatest proportion of expenditures assigned to inpatient treatment (Fenton et al. 1998).

When people with severe mental illness present to PESs in a crisis, they may not meet criteria for inpatient admission if they are not imminently dangerous. Nonetheless, they may lack the social supports and coping skills needed to return to the community or their former living environment. For instance, homelessness in and of itself does not warrant inpatient admission, but the stress of being or becoming homeless may necessitate psychiatric intervention. Thus, one option is a CRF, which would allow for stabilization and addressing housing issues in a supportive, residential setting. These facilities are an effective, less expensive alternative to restrictive and costly inpatient admission (McQuistion et al. 2008).

The growing numbers of persons with mental illnesses being treated in the community following deinstitutionalization have provided the impetus for the initial development of CRFs. Since neither the Housing Act of 1959 nor the CMHC Act of 1963 had provisions for residential facilities for people with mental illnesses, innovative programs arose out of necessity to find options to accommodate patients in community-based treatment. One such early program was a makeshift "crisis hostel" formed in Denver in 1970 as a way to stabilize patients discharged from the ED who were not yet ready or able to return to their previous homes. A registered nurse who owned the hostel administered medications for a maximum of 7 days, while local neighbors assisted by providing meals and additional support. Ultimately, when compared to a control group admitted to the hospital from the ED, these hostel patients had fewer inpatient readmission rates (Patel 2008).

Residential facilities are generally categorized by the level of clinical acuity and length of stay. Patients who need more urgent, short-term care (2 weeks to 2 months) or respite from environmental stressors can go to acute diversion units, dual-diagnosis facilities (halfway or three-quarter houses), or partial hospital programs. Less acutely ill patients who require longer-term care (1–6 months) can go to board and care homes, residential care facilities, or transitional living facilities (Patel 2008). Unlike the longer-term facilities mentioned above, CRFs are intended for acute stabilization and do *not* provide services for long-term maintenance or rehabilitation.

The majority of residential crisis programs are operated by private, nonprofit community behavioral health organizations and the most common model is a group residence that can accommodate between 6 and 15 people (Stroul 1988). Funding is most typically linked to government contracts for services and/or Medicaid reimbursement. It is noteworthy that in order to capture Medicaid funding, they must have fewer than 16 beds, or else by federal regulation be disqualified from reimbursement and classified as Institutions for Mental Disease (IMDs). Ideally, the residence is a neighborhood home and part of a community, although converted motels or office buildings that

minimize institutional features can also be used for this purpose. CRFs are usually unlocked and operate on a curfew, thus creating a comfortable, home-like environment that is less disruptive and stigmatizing than inpatient services. This allows consumers to behave as members of a temporary family unit and thus encourages responsibility, promotes healing, and facilitates smoother transition back to the community. Supportive relationships with staff are a key part of helping patients stabilize. Staffing patterns vary widely, but typically consist of paraprofessionals who consult with psychiatrists and psychiatric nurses. Having nursing staff in-house is advantageous, as the majority of the residents may need assistance with medications. On-site case managers also help clients reconnect with outpatient providers and community supports (Stroul 1988).

Admission to CRFs usually involves medical clearance because they are generally not equipped to monitor or treat medically unstable individuals. A staff nurse administers medication, or if nursing personnel are not available, residential staff can supervise people in self-administration. Patients are usually admitted to CRFs from the emergency setting and fall into three main categories: (1) those with severe mental illness who have experienced an exacerbation of their illness; (2) individuals in acute crisis due to environmental stress; and (3) patients who are quite distressed, but who do not require hospitalization or another type of highly restrictive facility in order to keep themselves and others safe. The average length of stay for an acute crisis in typical CRFs is 2 weeks, but it is not uncommon for patients to stay for up to 2 months until their social situation is more stable (Patel 2008).

A variety of people may use the CRF, but many who do have a history of multiple PES visits and psychiatric admissions are homeless with limited means, or have comorbid substance use or forensic histories. Crisis residential programs should be able to accept the most challenging individuals and be considered a placement option when other providers are unable to meet their needs. Despite this, certain individuals with active suicidal or homicidal intent, severe psychotic symptoms, dementia, or developmental delays leading to dangerous or impulsive behaviors are not appropriate for CRF placement. CRFs typically do not provide the level of security and staffing required to meet their needs.

It is clear that crisis residential services are an important and useful treatment option as an alternative to more costly inpatient admission. Patients dissatisfied with their past hospitalization experiences often prefer this option (Lloyd-Evans et al. 2009). However, there are insufficient studies looking at whether CRFs actually do effectively serve those with severe mental illnesses, for which they are usually targeted. The diversity of program types has prevented the creation of standards of care and thwarts efforts to study this treatment option.

Current reports are primarily descriptions of individual programs. Standardization would certainly fuel future research efforts, which should focus on ways to better classify CRFs, including: patient demographics and diagnoses, staff characteristics, medication management strategies, house rules, degree of personal autonomy, types of case management offered, and length of stay, among others. Finally, it is important to remember that crisis residential services are only effective in the context of a comprehensive community support system, which is ultimately what a person needs to function well in the community (Stroul 1988).

Future Directions

Inpatient treatment, while financially tenuous, is still important therapeutically as it provides a safe, contained environment in which patients can be engaged in a brief, intensive way and stabilized. Inpatient psychiatrists in the modern era of mental health treatment collaborate with other hospital-based services, including consult-liaison and the emergency psychiatry services, and general emergency departments (Casher and Bess 2010). They must also interface with MCTs and CRFs, which can provide step-down treatment and other disposition options that may not have been available previously, to better reintegrate people into community life.

This integration of care (inpatient and crisis services) is most evident in recovery-oriented services, particularly as it applies to consumers

with severe mental illnesses. Consistent with the principles of psychiatric rehabilitation, the emphasis is on empowering people to find meaning in their lives and overcome the limitations of their illness rather than settle for mere symptom relief. Nevertheless, many people with severe mental illnesses have special limits in coping skills and weakened social supports and come to the PES in a scenario that frequently leads to multiple hospital admissions. For many of these consumers, an intermediate treatment model is beneficial, eliminating the need for more restrictive and intimidating long-term hospital stays.

The idea of a "medical home" to meet the needs of people with severe mental illness is a comprehensive care approach that has been discussed in conjunction with accountable care organizations (ACOs) (see Chap. 5). These would focus on treatment of the total individual and integration of care across specialties. It would incorporate social supports, primary care clinics, chemical dependency services, and other resources to help patients achieve stability. It would also need to include urgent and emergent services such as MCTs, PESs, and crisis residential services. All of the above would then constitute elements of a comprehensive continuum of behavioral health care. As described by Alan Menikoff in his book *Psychiatric Home Care: Clinical and Economic Dimensions*, a "focused intervention driven by a philosophy of rehabilitation and targeted relapse prevention strategies must drive service planning (Menikoff 1999)." The parameters of the "psychiatric" home are still evolving, but the players are there and need to be integrated to best serve our population.

A truly integrated system of comprehensive crisis care does not exist in the United States, but there are several programs that come close and could serve as models for future programs. Table 31.1 a lists the components needed in such a system.

One is New York State's Comprehensive Psychiatric Emergency Program (CPEP), created and funded by New York State Legislature. CPEPs generally have a fully staffed ED around the clock, a crisis hotline, a 72-h extended observation unit, community-based crisis beds, rapid access to medical and pediatric EDs, and links to inpatient and outpatient treatment. Limited regional funding for emergency psychiatric services is a large reason similar programs have not arisen in other states, although the PES at the University of Michigan (UM) is an exception. The PES there is directly affiliated with the community mental health system via a partnership with the Washtenaw County Health Organization. Thus, in addition to linkages to the medical ED, crisis residential services, and the inpatient unit, UM's PES serves as the after-hours treatment center for the county's severely mentally ill population in crisis.

Table 31.1 Components of a comprehensive crisis care model

Physical and mental health services, provided directly or through links with local services
PES with observation unit
MCT
CRFs
24-h phone hotline
Addictions referral/treatment services
Supportive housing
Employment resources/rehabilitation
EMR accessibility
Link to local VAs
Clubhouse
Community reentry after release from prison/jail
Homeless outreach
Disaster response
Peer support/therapists
Family support and education services
Links to local law enforcement

The Re:Solve Crisis Network in Pittsburgh serves all of Allegheny County under one roof. It consists of a crisis hotline, a walk-in clinic, a short-term crisis residential program, substance use assessment and referral, and mobile crisis services. Extraneous services include crisis counseling to a local juvenile detention center, disaster response, and de-escalation training. Re:Solve prides itself on being recovery-oriented, autonomy respecting, and focused on providing the lowest appropriate level of care whenever possible. As a result, 85% of mobile crisis clients and 95% if walk-in clinic and residential clients are diverted from emergency departments and inpatient units.

Models such as these are worth emulating and building upon as the landscape of crisis intervention services evolves, all the while proving services in the least restrictive setting possible. However, crisis intervention services must be viewed in the context of the larger behavioral healthcare system to ensure that appropriate services and supports are provided even after the crisis has been stabilized. Delivering crisis intervention services from a narrow viewpoint, for example, emergency services only, results in repeated utilization of services without addressing underlying issues. The ultimate goals of improving access to resources and transforming crisis service from a reactive, repetitive process to one that is recovery-oriented will require coordination and collaboration with key providers and community agents across the behavioral healthcare system, combining, in turn, to influence policymakers.

In this chapter, the pieces of the puzzle have been described, but it will take time, energy, and the proper resources to help assemble them in a meaningful way. Now, more than ever, we need to develop an innovative model of comprehensive and integrated psychiatric services to enhance quality of care while also curtailing costs.

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32 International Trends in Community Mental Health Services

Alan Rosen, Paul O'Halloran, and Roberto Mezzina

Introduction

A global survey of community-orientated mental health reforms and services is presented. We cannot hope to provide an exhaustive international survey in such a short space, so we will describe examples of which we have first-hand knowledge, focusing on some leading edge aspects of community mental health service innovations or systems reforms in different countries. These include community crisis and early intervention services, community residential respite and rehabilitation/recovery services, interventions for prevention of suicide and deliberate self-harm, community care management and assertive community care services, community-based day programs, and vocational services. Although the countries discussed are different on many levels, it is intriguing to note that there are consistent themes across these nation states: recognition that institutional hospitalization does not offer maximal therapeutic support or care; a movement towards provision of mental health services in the community; innovation in community care, including housing, work, legislative reform, the need for committed leadership, adequate funding, and stigma reduction; and the imperative nature of increasing the mental health workforce and enhancing its skill-set to encourage recovery-oriented treatment.

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Australia and New Zealand

The history of Australian and New Zealand psychiatry is entwined with the impact of European (British) invasion and settlement, initially in Australia, in 1788, to form penal colonies to alleviate the overcrowding of English jails, which generated a masculine-dominated, individualistic culture. As European settlement in Australia and New Zealand expanded, the colonists tried to come to terms with the remote, vast landscape of Australia, and the rugged, stunning vistas of New Zealand, and fought over land and resources with the original Aboriginal and Maori inhabitants, the former of whom had been there between 40,000 and 60,000 years. Culturally congenial methods of working with indigenous people are

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being integrated into mental health services in both countries, e.g. training and employing indigenous mental health workers. With accelerating European and Asian immigration, particularly since the 1950s, both countries have become increasingly multicultural in their approaches.

Australia: A Cautionary Tale

Australia serves as an example of a country whose mental health provision structure is evolving from institutional to community-based care. It has struggled with translating plans into service and reflects how programs can degrade without consistent leadership, funding, and coordination.

By the mid-1950s, occupation of psychiatric institutions reached its peak in Australia. De-institutionalization occurred in the 1960s and 1970s, but without significant community supports in place. In a move to appropriately shift mental health care from institutions to the community with adequate planning and funding, the First Australian National Mental Health Policy was endorsed in 1992 by all Australian health ministers. It provided transitional funding in the national budget through the accompanying National Mental Health Strategy. There have been four distinct phases of the National Mental Health Strategy (Department of Health and Ageing 2005; Rosen 2006a, b).

First National Mental Health Plan (1993–1998)

Services were to be shifted from stand-alone psychiatric hospitals to become largely community-based, "mainstreamed" services, integrated with and accessible via general health services, although remaining distinct as specialized mental health services. This included 24/7 mobile community-based mental health crisis intervention services, assertive community treatment (ACT) teams, a range of supervised community residential facilities, community vocational rehabilitation services, and social recovery services, integrated with local psychiatric inpatient units based in general hospitals. They were to develop strong links with groups of consumers, families, general practitioners, the nongovernment service organizations, and other nonhealth services, such as housing, disability services, social security and employment (Buckingham et al. 1998).

Second National Mental Health Plan (1998–2003)

This plan focused on the principles of mental health promotion, prevention, partnerships with other (non-health) providers of services, and quality. National media and educational strategies to minimize stigma and discrimination due to mental illness were devised and disseminated (Rosen et al, 2000). A new emphasis on early intervention programs began to emerge based on the internationally pioneering work of McGorry and colleagues in Melbourne (http://www.orygen.org.au) (McGorry and Jackson 1999; Department of Health and Family Services 2002).

Third National Mental Health Plan (2003–2008)

There is now broad agreement that the Third Plan, despite a welcome focus on service responsiveness and partnerships, lacked real accountability mechanisms and provided few incentives to the states to complete even the first two Plans (Australian Health Ministers 2003; Department of Health and Aging 2005). Accordingly, the substantial early achievements of the National Strategy began to fray, and gaps in services began appearing as evidence-based community services were short-funded, diluted, and/or retracted increasingly to hospital sites (Rosen et al. 2010a) There was also an unanticipated growth in acute presentations of comorbid drug abuse and mental illness (Gurr 2005), which overwhelmed emergency and inpatient departments.

Media glare on the human consequences of these problems led to serial national inquiries by the Mental Health Council of Australia (Groom et al. 2003), the Human Rights and Equal Opportunity Commission (2005), and the Australian Senate (2006). In response, a substantial injection of federal funding occurred, focusing on paying largely for nonprofessional support workers to be provided through the nongovernment sector, subsidizing private fee-for-service counseling for higher prevalence milder mental health disorders. The states were unsuccessfully

challenged by the federal government to match funding to enhance core public services for lower-prevalence severe conditions. Unfortunately, in order to maintain party political control of them, these new federally funded services were deployed in new silos without any articulation or coordination with existing state-operated public mental health services.

Fourth National Mental Health Plan (2009–2014)

Accompanied by a new national mental health policy and revised national mental health services standards (Miller et al. 2009; Rosenberg 2010), it signaled a further retreat from full consultation of stakeholders and the bureaucratic dilution and downgrading of the national strategy with few specified objectives, goals, targets, or timelines (Rosen 2009).

Advocacy

The Mental Health Services Conference of Australia and New Zealand (http://www.themhs.org) has evolved over the last 21 years into a "strong independent movement" (Andrews 2005) conducting bi-national forums twice yearly, led by a broad coalition of all mental health professional, mental health leadership and management, consumer, family, transcultural and indigenous networks. It organizes binational forums for evidence dissemination and debate that push for greater momentum in mental health service reform. In 2010, a pervasive on-line national public lobbying network ("Get-Up") took on mental health and campaigned strongly, particularly for youth mental health.

Politics

As time and deficiencies in mental health services progressed, public awareness was expanding. A temporary National Health & Hospitals Reform Commission found in 2009 that mental health, among other long-term conditions, badly needed public funding for a more consistent shift to 24 h continuous community services, equitably deployed across the country. This priority was ignored or postponed by the new prime minister who had ordered this commission. He focused almost entirely on acute high-tech hospital care and primary care and was subsequently deposed by his ruling labor colleagues. For the first time in Australia, the need for better funded mental health services became a hotly contested issue at a recent federal election, with all three major parties competing with well-publicized mental health policies, bearing fruit in 2011 with enhanced funding in the national budget. So far, funding created few evidence-based community services, with questionable mechanisms for the coordination of vocational, residential, and clinical services (Rosen 2011). However, one national and four state mental health commissions are forming, with a governmental commitment to revive and transparently account for recovery-oriented mental healthcare reform (Rosenberg and Rosen, 2012).

Implications

Structural reform of mental health services is easier to achieve than improvements in service quality; support of clinicians, consumers, and care providers is a critical factor in the success of mental health reforms (Whiteford and Buckingham 2005). Mental health reform in Australia looks good on paper and has been heading broadly in an appropriate, more community-focused and recovery-oriented direction. However, these reforms have been losing momentum. Core local public community mental health services are being eroded or have never developed sufficient breadth (Rosen et al. 2010a). After a period of sustained growth in spending on mental health services, and following a lull, even with recently announced enhancements for the next 5 years, Australia still lags behind similar Western countries in terms of the proportions of gross domestic product and national health budget spent on mental health services (Rosen et al. 2004, 2008; Hickie et al. 2005; Rosen 2006a, 2011). Strong independent advocacy from several new reform-oriented Australian mental health commissions may be able to convince governments to remedy this (Rosen et al. 2010b; Rosen 2011).

New Zealand

New Zealand has had the benefit of being a close observer of high-level decision-making regarding

Australian reforms, learned from their mistakes, and was able to embark on a much improved parallel process. In the absence of an Australia-like moderately well-developed private sector in psychiatry, New Zealand created a viable market for the purchase of health services from public sources and nongovernmental organizations (NGOs), including mental health services via regional and later from (less successful) smaller district-based health service purchasing authorities, that could tightly contract, balance, and integrate service components from either public or nongovernment not-for-profit agencies.

New Zealand's Mental Health Commission, established in 1996 with a bipartisan political mandate to run until 2015, was the *first* worldwide to adopt a system-wide reform agenda as its priority (Mental Health Commission 1998, 2001, 2010). It has employed transparent accountability principles in monitoring the quality of all mental health services; independent service providers and government; recovery-oriented competencies and workforce development (O'Hagan 2001); and grassroots strategies for challenging stigma ("Like Minds, Like Mine," http://www.like-minds.org.nz/page/5-Home). One of the most important initial achievements of the New Zealand Commission was to produce in 1998 the Blueprint, a detailed plan to offer mental health services with a recovery agenda to be developed in regular consultations with all stakeholders, especially including indigenous people. Financial planning and commitment for the Blueprint from an incoming government has enhanced the caliber and consistency of mental health services remarkably. The result in New Zealand is that more than 80% of mental health services are now provided in the community with 30% of mental health budgets spent on strict contracts with the NGO sector to enhance community services (whereas Australia struggles to attain even 50% community provision and, the average spend on NGO's in Australia still hovers around an average 7–8%) (Rosen et al. 2010b).

New Zealand's per capita expenditure on mental health far exceeds Australia's, by more than 100% of public and NGO funding and by 50% of private practice income. New Zealand now spends 11% of its health budget on mental health services, whereas in Australia, this proportion continues to decline, in spite of the fact that the average burden of disease due to mental ill health is 14% of all diseases internationally. However, so far, the impact of the global financial crisis has been much more severe in New Zealand than in Australia, and consequently, the budgets of both public and NGO services have been cut back, and the commission's budget, scope, and independence are under threat of being curtailed under the current conservative government.

Canada

Canada has an impressive record of community mental health innovation, and of being early replicators and adopters of evidence-based community-based initiatives (Wasylenki et al. 1985, 1993). Earlier programmatic examples include a collaboration of greater Vancouver's "Car 87" joint mental health and police crisis intervention team with Venture House, a community sited 24-h low-key respite facility (Torrey et al. 1993). Other key initiatives include crisis intervention and integrated care delivered in naturalistic settings (Mercier 1990), system-wide implementation of ACT in Ontario (George et al. 2009) and Quebec (Latimer and Nadeau 1998; Latimer et al. 2011), and the rolling out and researching of optimal community oriented initiatives for homeless individuals with mental illnesses, including those of Native American and transcultural backgrounds, especially concerning comprehensive rehousing (Wasylenki et al. 1993; Goering et al. 2002; Strike et al. 2002; Mental Health Commission "Housing First" initiative 2011). Early psychosis intervention teams have been extensively developed and researched especially in Quebec, Alberta and Ontario (Malla et al. 2005; Addington et al. 2005; Addington and Addington 2006). For example, researchers from Sickkids Hospital in Toronto were instigators of the first international network of qualitative research and implementation studies of mainly community-based early psychosis teams (Boydell and Ferguson 2011). Quebec has become an

international center of renoun for health economics studies of the cost-effectiveness of community vs. hospital-based mental health delivery systems (Latimer and Nadeau 1998; Latimer et al. 2011). For the first time in a federated nation, Canada's prime minister launched in 2007, and with bipartisan political support, a Mental Health Commission. It has responsibility for developing a national mental health strategy with a strong orientation towards community care, a publicly accessible knowledge exchange center to encourage the rollout of more evidence-based and recovery-oriented care, a community awareness and anti-stigma strategy ("Opening Minds"), and a socially inclusive movement to carry its work on beyond its 10-year mandate (MHCC 2007–2011).

United Kingdom/Britain

In 1998, the UK Secretary of State for Health Frank Dobson noted that, "Care in the community has failed" (Burns and Priebe 1999), referring to the process of deinstitutionalization in the UK, the closure of the old mental asylum system, and transfer to the community of patients. While movement into the community for some patients had been beneficial (Leff et al. 2000), for others it had led to homelessness and dislocation from care and community (Craig 1998). Dobson was recognizing that simply discharging many long-stay hospital residents (155,000 in 1954 to less than 20,000 in 1998) into the "non-system" of community care had been a mistake (Keown et al. 2008).

In 1999, the National Service Framework, NSF, for Mental Health was published (DoH 1999) outlining a quality framework for services. This was accompanied by NSF's detailed strategic approach to implementation of community care, known as the NHS Plan (DoH 2000). Based on seven national standards, the NSF clearly spelled out for the first time a blueprint for community-based services. Building on the best evidence available at the time and drawing heavily on overseas experience of implementation, particularly Australia, the NSF/NHS Plan for Mental Health set out, for the first time in the UK, a clear and progressive national policy. Importantly, it included a very prescriptive, centrally driven, performance-managed and relatively well-funded 10-year plan of implementation.

Strategic drivers for change included not only the development of new standards in key areas of mental health, but also the introduction of an evidence-based approach to interventions and service models, showcasing examples of good practice as well as monitoring performance and measuring progress.

The performance management dimension was taken forward through a number of strategic drivers including the setting of clear targets, centralized monitoring, decentralized local commissioning arrangements through primary care based entities, Primary Care Trusts (PCTs), involving purchaser-provider splits, and payment by results. The process of using quasi-market forces, including the development of a more competitive provider environment, together with the redevelopment of NHS Trusts (the main provider entity of public mental health), liberated local planning from a top-heavy and top-down approach, creating more locally responsive business type entities and enabling better integration of health and social care functions that facilitated progressive secondary care provision.

In addition, priority was given to expanding and reforming the existing workforce through the introduction of new roles and tackling traditional practices. Collaboration with professional and accrediting bodies and higher education institutions, the introduction of progressive training and educational methodologies, and development of more flexible approaches to the demands of a needs-driven and community-based system have all been pursued under the leadership of the National Institute for Mental Health in England (NIMHE 2004). As a result, specialist mental health services have seen a significant rise in government funding with an increase in annual investment in services of over £1.5 billion annually. Workforce reform has led to an expansion of new roles in the practitioner workforce, including 1,000 new primary care mental health workers, 500 additional gateway or liaison workers to work with primary care providers, and approximately 3,000 recovery support workers, many of them

people with experience in recovery. In addition, traditional clinical roles have been expanded, with an extra 1,300 consultant level psychiatrists, 2,700 clinical psychologists, and around 10,000 mental health nurses. Service users and families are reporting high levels of satisfaction with the treatment and care received. More than 77% of respondents in national surveys rate the care received as Excellent, Very Good, or Good (Appleby 2007; DoH 2007, 2009).

So, after the NSF, where does mental health reform go next? From 2010, New Horizons, the UK's new national mental health policy, building on the previous NSF achievements, set a direction characterized by a greater focus on self-management, emphasizing social outcomes of work, housing, and inclusion. It is also characterized by a much less centrally driven approach, with less prescription and greater opportunity for local responsiveness. Drivers for these changes underpin some of the most radical reforms in NHS history, with a dramatic shift away from a centrally controlled, quasi-managed market arrangement towards a free-market mechanism with limited political interference in system management. Increased use of market forces is aimed at driving up quality and increasing choice, through encouraging a "plurality of providers." Use of direct payments and individual service-user budgets will break up traditional block contracts to traditional provider organizations, opening the market to alternative providers and increasing choice. Change will also be characterized by a greater emphasis on outcomes rather than inputs, with significant structural reorganization, and greater integration of the specialist functions as represented in the various specialist teams.

Along with new opportunities, there are also risks and challenges. Much will depend on the general practitioners' capacity to determine need and to put in place effective and comprehensive services. With a plurality of providers, the question of integration, coherent pathways to care, and whole system functioning has been raised. In addition, the reality of introducing workable outcome measurements on a routine basis including those for established long-term conditions such as serious mental illnesses will remain a key challenge. Reform continues, as it pushes for community treatment, 24 h per day/7 days per week on-demand accessibility, early detection and prevention, consumer-centered care, evidence-based practices, care-coordination in a multidiscipline approach, and greater promotion of client self-management and peer support approaches. The challenges that lie ahead include how a national health service with a tradition of providing clinical treatment will deliver much more on social outcomes, such as employment, housing, and whole life recovery outcomes. This will necessarily require greater integration and closer working with public welfare, the voluntary sector and social services partners, and the establishment of better connections with the local community.

Italy

A Short History of Law 180

Learning from the experience of the historical and decisive anti-institutional movement in Italy is fundamental. This movement, which began with the pioneering experiences of Franco Basaglia and others in the 1960s and 1970s, resulted in Italy's renowned psychiatric reform Law 180 in 1978 (Basaglia 2000). Italy was the first in the world to mandate halting all admissions to mental hospitals. Inpatient units were limited to 15 beds and attached to general hospitals, while most clientele were cared for by community mental health centers (CMHCs) and/or relocated to community dwellings serviced initially by institutional staff and later by cooperatives operated for and with consumers and served by the CMHCs. It led subsequently to the healthcare goal plans of the 1990s and generated the political clout necessary to finally close all psychiatric hospitals and bring the Asylum Era to an end in the country by the conclusion of last millennium.

The reform act was just a framework for subsequent acts (regional laws, national and regional healthcare plans), but they lacked specific policies and suffered from competing levels of administration and finances, planning, and modeling of services. In the early stages, the inadequate

financial investment and resources intended for the new services did not support sufficient staff numbers and restricted opening hours in the most of Italy. The closure of all mental hospitals occurred 22 years later, as different service provisions were encouraged. Social acceptance of the law and a general decrease of stigma attached to psychiatry mark a series of fundamental changes in public attitudes. Families advocated strongly for improved community services and demonstrated a burden much more reduced than in other European countries (Basaglia 2000; Magliano et al. 2002).

The Current Situation

Even if there is presently an adequate number of community mental health centers (about one center for every 80,000 people), the way they are operated remains contentious. A well-staffed and well-resourced CMHC which is mobile, assertive, and proactive can be the core of a mental health department as the one-stop shop for all psychiatric requirements of its catchment areas. Unfortunately, weak and unfocused community-based services in other regions provide neither alternatives to crisis care nor long-term support and rehabilitation. A weak community-based system of care usually produces "residual patients" who became stuck at first, as "guests" in the declining mental hospitals and then later in residential community settings.

Compulsory treatments dropped dramatically after 1978 as an immediate effect of Law 180 and have sustained the lowest ratio in Europe (25/100,000). Some general hospital units are still inadequate and suffer from the use of restraints. In some regions, there is also a high use of short- and medium-term admissions in private hospitals (De Girolamo et al. 2007). Small sheltered community-based residences expanded to more than 17,000 places by the end of the 1990s (De Girolamo et al. 2002). It is noteworthy that in Italy, rehabilitation and reintegration of former long-term patients in transitional community residential settings is more extensive than in any other western country.

In such a context, for people with mental health problems, recovery includes citizenship and social reintegration. Social cooperatives have been developed as one vehicle to enhance such reintegration. These are social enterprises which try to be competitive in the market, involving people with mental illness as service users, as well as other citizens, in work activities that include agriculture, building, cleaning, tailoring, hotel operation, restaurant, and home catering businesses. All workers, except trainees, are voting members of the cooperative businesses. The first one in Trieste started as a practical response to exploitation of mental health patients in the cleaning of the mental hospital in order to ensure they were able to work (and get paid) at trade union rates. More than 4,500 cooperatives are now operating in the country. These enterprises must include at least 30% disabled service-users to get a tax break to help them sustain a viable business (Leff and Warner 2006). The forensic sector still requires further deinstitutionalization. In forensic mental hospitals, still supported by existing penal legislation, a total of about 1,500 patients are detained, mostly in very bad conditions. Only recently are there more effective policies aimed at overcoming those very backward total institutions; this point calls the action of mental health departments to be responsible for alternative and comprehensive programs of care, either for the discharge or for the effective prevention of new episodes.

Trieste: An Exemplary Model?

Trieste is one practical example of how the Italian movement achieved deinstitutionalization. In other countries, the situation is conceptualized as a bed-reduction process, limiting institutional resources. In Trieste, however, there was a complex process resulting in the gradual relocation of the economic and human resources and subsequent creation of 24 h CMHC's, with former inpatients gradually placed in alternative accommodation outside of the hospital. An exploration of the hierarchical social organization as a repressive apparatus even for the staff occurred; the

hierarchy was dismantled and replaced by a more flexible organization. A transfer to a nursing staff of increased autonomy commensurate with increased abilities and new skills, and a critical examination of the traditional psychiatric ideology led to a profound change in the operative philosophy, moving from a policy of intervention to one that supports the basic needs of people (Rotelli 1988; Bennett 1985).

According to the WHO (World Health Organization) (WHO 2001a) ("Stop exclusion—Dare to care," WHO 2001b), Trieste's 40 years of experience in the field of mental health and the recent extension of the integrated, community-based system to the area of basic health care in the form of the Health Care Districts is an example of proven success. The most notable achievement reported after the psychiatric hospital was shut down in 1980 after a 9-year process was the creation of a system of community services which completely replaced the old asylum (Dell'Acqua and Cogliati Dezza 1986; Dell'Acqua 2010). Four CMHCs were made responsible for small catchment areas of 60,000 on average, working 24 h/7 days per week with 4–8 "hospitality" (crisis respite) beds for a normalizing and effective crisis care (Mezzina and Johnson 2008). The organization and philosophy of these CMHCs was based on the principles of: (1) nonselection of demand (i.e., not based on particular diagnoses, severity thresholds, or other exclusion criteria); (2) nonhospitalization; (3) service flexibility and mobility; (4) the involvement of multiple comprehensive resources, such as a wide range of welfare provisions, in the therapeutic and support programs (Mezzina and Vidoni 1995). Presently in Trieste, 94% of the mental health budget is spent in the community (18% directly to personalized and budgeted packages of care), with only 6% of the budget going to a 6-bed general hospital-based service that acts as an emergency first aid station at night. The wide range of responses include: congregate supported housing for about 50 persons located in the city; job training and placement for about 250 service users annually, with more than 20 service users becoming full-time members/employees in the participating social co-ops and businesses each year; and day centers, social clubs, community agencies and associations, including sport and cultural ones, as active partners.

What was recognized as an experimental WHO pilot area of deinstitutionalization in 1974 (Bennett 1985) has now demonstrated that a city like Trieste can manage without an asylum and that care can be provided while at the same time providing maximum safeguards for individual freedom. This means abolishing all forms of intrusive treatments, such as physical restraint and ECT, using compulsory treatments only when absolutely unavoidable (7/100,000 inhabitants annually), and making a continuous effort to avoid referrals to forensic hospitals, while working to release those very few users who have been incarcerated. Among the Service's most relevant outcomes is contributing to the reduction of suicide rate by half, from 25/100,000 in the mid 1990s, to 12/100,000 after a decade (Dell'Acqua et al. 2003), with the contribution of a dedicated prevention project, bringing what was a disturbingly high Central European suicide rate to one which is on a par with other Mediterranean countries (Mezzina 2010).

The "Italian way" thus remains a model precisely because its community services and good practices derive directly from the process of deinstitutionalization and its resultant transformation, not only in institutional terms (i.e., eliminating the asylum) but also with respect to the philosophy of intervention, the values expressed, and the role and social significance of the services (De Leonardis et al. 1986; Toresini and Mezzina 2010).

Other European Countries

In the last 12 years, some of the best practices in community mental health endeavored to establish network organizations, like the IMHCN (Jenkins 2010). Through collaborations and educational meetings, exchanges on innovative services and programs have encouraged continued growth in European mental healthcare system. Examples of these are host or adult foster family schemes as seen in Gheel, Belgium (see Chap. 2 for details), practices in community and social

integration (Lille, in France), development of more flexible/less rigorous variants on ACT teams (Netherlands), 24-h opened centers (Stockholm), and social firms (Oviedo and Seville, Andalucia, in Spain).

In the Netherlands, Arie Querido pioneered citywide mobile crisis team management in Amsterdam as an alternative to hospital-based care, comprising a psychiatrist and a social worker home visiting clients in crisis and creating follow-up plans, endeavoring to deal with social factors precipitating mental disorders (Querido 1935). In recent years, many innovative community residential programs have been developed in Holland as alternatives to psychiatric hospitalization, but the health insurance company-driven, semi-privatized system of payment continues to provide incentives favoring hospital-based care. ACT has been studied in the Netherlands, with only one randomized controlled trial demonstrating improved engagement and satisfaction with care, but no difference in terms of reduction of hospital days (Sytema et al. 2007), which may be understandable in the context of the vast supply of and ease of access to Dutch public psychiatric hospital beds (150/100,000) relative to English-speaking countries, where most ACT research has been done (Killaspy and Rosen 2011). An interesting flexible variant of ACT ("FACT"), with a 1:20 service provider to user ratio providing intensified case management for people whose illness is in exacerbation or remains very disabled, has been widely adapted in the Netherlands, though no rigorous evidence as yet for the model (Killaspy and Rosen 2011). However, it has refocused interest on ACT and was the impetus behind the Netherlands hosting the First European Congress on ACT in 2011 (van Veldhuizen 2011).

Oviedo and Asturias in Spain nearly contemporaneously with Italy were first to close their asylums and begin developing community services (Aparicio Basauri 2010), followed thereafter by Andalusia and Navarra. In fact, there were 120 psychiatric hospitals in 1975, with 91 still functioning in 2003, coexisting with a mix of community services. There was a national health law in 1986 but regional models were very autonomous (Aparicio Basauri and Sanchez Gutierrez 2002). Since 1993, a foundation (FAISEM), aimed at social integration, including community residences and social enterprises, coordinated health sector and welfare interventions in Andalucia. Job orientation and supported employment in the open market has been actively provided. There are 15–30 beds in general hospital units, day hospitals, rehabilitation communities, and community mental health teams (López 2004).

In France, services in Lille also continue to develop, but in their high-minded pursuit of the rights of citizenship ("citizen psychiatry") that include participation, integration, and civic and social inclusion, community mental health services remain in relative isolation in that nation. Though still linked to a ward of the old psychiatric hospital with very few beds, almost by way of compensation, services do have presence in the community with a network of innovative programs and resources, from foster families for persons in crisis, to user groups and a wide variety of residential solutions (Roelandt 2010). However, despite the Health Ministry's promises that France would follow the example of Italy (2001), the asylums were left essentially intact, many reforms were blocked, and secure beds reinforced. On the positive side, the presence of some exemplary community experiences and a gradual reduction in the number of hospital beds should be noted.

Stockholm, Sweden, eventually closed its asylum and is modeling services after the example of Trieste and added 24-h mental health centers, social cooperatives/social enterprise businesses, and service user involvement. In recent years, this experience has become a paradigm of *recovery*, in which those with direct experience of mental suffering take a leading role in their own healing, and with inclusion processes, make it a key factor in transforming systems (Topor 2001). The separation of healthcare and welfare was sanctioned by a 1994 law which, even in an all-inclusive welfare system like Sweden's, often lets vulnerable individuals "slip between the cracks," once again confirming the need for integration of public services.

In the 1990s in Greece, a vigorous international commitment to deinstitutionalization occurred

in response to a "scandal" at the mental hospital on the island of Leros, resulting in partial positive changes. Unfortunately, the availability of resources for mental health service reform remains much lower. Community services are still underdeveloped, while residential units, even those run by big mental hospitals or by welfare services, are often still based on institutional rules and treatments. Hence, a move towards transformation is now undermined by forms of transinstitutionalization.

South Eastern Europe (The Balkan States)

The region of Southeastern Europe, commonly known as the Balkans, is home to approximately 58 million people and consists of nine different countries. The region has a long history of political repression and instability, poverty, deprivation, and war. Most recently, in the early to mid 1990s, following the collapse of the old communist state of Yugoslavia, events fueled by extreme nationalism erupted into violent religious and ethnic conflict centered in Serbia, Croatia, and Bosnia Herzegovina.

This is the backdrop to the WHO-led and European Union-funded program of mental health reform across the region, beginning in 2002 and extending through to 2008 (WHO 2009; Regional Project Office 2005). The existing mental health systems in these countries at the time were characterized by traditional hospital bed-based services centered on custodial institutions. There was an almost total absence of state-funded community mental health services, along with a paucity of nongovernmental agencies devoted to supporting people with mental health problems in the community. Fragmentation, disconnection, and disinvestment also characterized other relevant services including primary care. In terms of workforce capacity and capability, clinician numbers needed significant growth with a concomitant expansion and development of contemporary methods of practice. A widespread culture of stigma, discrimination, and political neglect, reinforced by a policy vacuum and lack of mental health legislation, created a pervasive environment of stagnation, where reform efforts found little traction.

The strategy of reform focused on several key areas including scaling down the old mental hospital by lowering rates of new admissions and reducing existing bed occupancy, building services in the community, and developing the mental health workforce to provide more recovery-oriented and evidence-based practice. After 6 years of development from 2002 through to 2008, common achievements across the nine countries have included the development of individual national mental health policies and national and local strategies of reform, including legislation. In terms of concrete services, each of the nine participating countries has implemented at least one pilot CMHC staffed by a multidisciplinary team of psychiatrist, psychologist, social worker, and nurses, trained in case management. Persistent problems include insufficient levels of ongoing funding by local governments. The existing CMHCs continue to survive, but are not thriving and have not acted as the nucleus of more widespread roll-out of community mental health services within each country. The old mental hospitals have not experienced any serious downsizing so that mental health funding remains locked into outdated systems of care that continue to exert a powerful and negative influence on reforms and act to slow down changes in practice (WHO 2004).

Latin America

In the 1970s and the 1980s, the influence of Italian Reforms in psychiatry in Brazil and Argentina was greater than everywhere in the world (Delgado 1991). Basaglia's impact in Brazil in 1979, as recorded in "The Brazilian Conferences" (Basaglia 2000), was enormous and seemed to be perfectly in tune with the political movements of that time. Then the first federal reform law was applied in the 1980s with the creation of Community Mental Health Services, with all States maintaining their autonomy in the process of phasing out of mental hospitals (Nicacio 1990; Levine, 1996; Larrobla & Botega 2001).

In the 1990s, the city of Santos, Brazil, applied a very innovative program of community mental health services formed on the Trieste model, using resources of a former private hospital. Thus, the National Health Law of 2001 guaranteed full citizenship to people with mental health problems and fostered the growth of community-based services. This resulted in a clear and impressive shift from psychiatric hospitals to community-based services in the following decade. In fact, from 2002 to 2011, expenditures decreased from 75 to 29% for the former, and inversely increased from 25 to 70% for the latter (Tykanori 2011). While about 19,000 beds were closed in hospitals, 3,000 long-stay beds were created in group-homes and in short-stay beds in CMHCs. The democratization process in the public sector was conceived in the framework of a welfare community and social economy, linking mental health to other governmental sectors in the provision of housing, work, and income within the framework of a national program of poverty eradication (Tykanori 2011). The anti-asylum mass movement has again restarted with service users, carers, and professionals allied together.

Argentina developed some pilot models in Cordoba in the late 1980s and the 1990s. In Rio Negro, a regional law, also strongly influenced by Italian reforms, favored the reconversion of psychiatric institutions into a network of effective community services and work cooperatives for service users (Cohen and Natella 1995). The reform in Argentina's Río Negro Province, an experience that from the outset had both enthusiastic supporters and relentless critics, was one of the first reforms to successfully implement an integrated mental health system with no psychiatric hospital in a large territory, with a significant component of psychosocial rehabilitation and extensive patient participation. This significant change resulted from policies designed to correct trends seen in the 1960s and 1970s, during which military dictatorships supported an explosive growth of private psychiatric hospitals (Caldas de Almeida and Cohen 2008). In 2008, more than 25,000 inpatients were still in Argentine mental hospital living in deprivation of their rights and dignity (CELS 2009). After many conflicts, in 2010, a new law was applied that was similar to the Italian reform Law 180 of 1978. The closure of mental hospitals was declared a goal, with the rights of people with mental health problems considered as the focus.

One important aspect of newly implemented mental health policies in several countries was the integration of mental health into primary care. The Cuban experience was the first to include mental health in primary care as the basis of the new mental health system and to implement this strategy at the national level. The existence of a network of primary care covering the entire population was certainly a factor that greatly facilitated this strategy, but arguably (Caldas de Almeida and Cohen 2008) it would never have been implemented without a detailed mental health plan, making it possible to train professionals, create specific programs, and develop new facilities in the community.

Asia, Africa and the Middle East

Evidence-based global health initiatives for both developing and developed countries are now encouraging a shift of focus from hospital-centered and institutional care to community-based care (Lancet Global Mental Health Group 2007), with closer linkage to primary health care. Parts of rural India have excelled at low cost community-based rehabilitation (Thara et al. 2008). Meanwhile, China has begun to devolve more institutionally based mental health services to community health centers, and in some instances, to outpost centers located in large residential blocks or complexes. Augmentation has occurred experimentally with community-based individual and group family sessions focusing on enhancing marriage prospects of affected offspring as well as psycho-educational techniques (Xiong et al. 1996) and more routinely using traditional herbal remedies jointly with orthodox antipsychotic medications, for which there is now preliminary evidence of better outcomes than using the latter alone for psychoses (Rathbone et al. 2007).

Nigeria: The Village System

The origin of contemporary community mental health services, certainly in the developing world, but arguably also in the West, owes a huge debt to Dr. Tom Lambo in Nigeria. Having been delayed in 1954 in the rebuilding of the Aro Psychiatric Hospital, Lambo initiated a system of village care of individuals identified as acutely or severely mentally ill. It relied on occupants of several villages nearest Aro taking these individuals into their homes as lodgers for a very small fee, while a combination of nurses, doctors, and local traditional healers jointly provided care in the villages with a 24 h on-call service providing emergency cover from the main village. Unfortunately this system, which service users found very congenial and approachable, and which therefore was able also to provide effective early intervention, was dismantled when the hospital was ultimately rebuilt (Asuni 1967; Adewunmi 2002).

The Palestinian Territories: The West Bank and Gaza

Since 2004, the WHO and various European Union donors have supported an ambitious program of development of mental health services in the West Bank and Gaza, with contributions of technical expertise and direct funding amounting to approximately five million Euros. This has resulted in the development of a national mental health policy and a strategic implementation plan, relatively rare achievements in this region of the world (Bassam 2005; Palestinian National Authority 2004). The main thrust of the plan entailed developing local CMHCs located close to primary care centers, in each of the regions of the West Bank and Gaza; building mental health policy and planning capacity within the Ministry of Health; retraining the practitioner workforce through in-service team instruction and building university-based, postgraduate professional education courses, especially for nurses and psychologists to attract the future clinical workforce; establishing family and user associations including public awareness campaigns to help overcome stigma, discrimination, and misunderstanding; and developing new mental health legislation to protect human rights (WHO-AIMS 2006; Palestinian National Authority 2004).

By 2010, actual results have included the building of some form of CMHC in each district linked to local primary care services. Additionally, all teams have received some form of in-service training focusing on case management. Further, postgraduate education programs have been established at the Islamic University of Gaza (IUG), the An Najah University in Nablus, and Ibn Sina nursing College at Ramallah, accepting up to 60 nurses annually into masters levels programs. A postgraduate diploma in Psychological Therapies was also established in Gaza at the IUG. Improvement in the quality of clinical service provision in the CMHCs and reform of the old psychiatric hospitals in Bethlehem in the West Bank and in Gaza City, which continue consuming around three quarters of the relatively small mental health budget, remain as continuing challenges (WHO-AIMS 2006). Despite major ongoing challenges, this initiative presents an outstanding achievement relative to all other public mental health developments in the region, particularly so in the context of the stress and trauma of continuing conflict and intermittent war.

Conclusion: Global Community Mental Health Practice of the Future

Much work has been done internationally on the roles, teamwork, leadership, training, and future scope of the work of community mental health practitioners (Rosen 2006c). The terms "community psychiatrist" or "community mental health practitioner" should signify an exhortation to "go wider" in seeking rigorous training and experience in both the *microsphere* of direct holistic clinical and functional care and the *macrosphere* of improving the well-being of whole communities (Rosen 2006c). Many of these experiences, particularly for those who came to terms with old institutional care and thinking, are now emerging as practice-based evidence and outline a real paradigm shift from an illness-focused psychiatry to a person-centered mental health and well-being paradigm (Mezzina 2005).

Finally, are community mental health services caught in a recurrent time warp? Are we destined

to fight the same battles to save community mental health over and over again? A shift of gravity of mental health services to community-based care is squarely supported by worldwide evidence and is long overdue in some countries. However, community teams and facilities do not have a high public profile, unlike salient and brooding hospital complexes, so they are vulnerable to variable and chronic underfunding and recurrent attempts to relocate them on hospital sites and dismantle them on the spurious basis of economy of scale (Rosen et al. 2010b). Some argue that mental health reforms with a marked ideological component and that are extremely dependent on charismatic leaders are especially vulnerable, given leadership changes and the political powers on which they depend (Caldas de Almeida and Cohen 2008). It may be that charismatic leadership can be really useful, but only in a formative stage of any new initiative, in the transition to reform, and that consolidation and sustaining of that reform relies on a much broader leadership group (Rosen et al. 1997). However, there is no monopoly on ideology: institutionally centered services have been defended on the basis of ideology and without evidence for several centuries. Similarly, there remains an evidence-free reactionary zone defended by a vocal minority of hospital-based clinicians arguing against a shift towards community care. Furthermore, many pioneers of community services state that they were never characterized as charismatic until they succeeded (Hoult 1983, Personal communication) and prefer that their reforms be judged not on their theories but on evidence of improved outcomes.

Key lessons from all these initiatives relate to planning for sustainability and the need to undertake proactive and progressive reform of existing institutional structures such as the old style asylums. We need to not only redistribute limited resources to the community, but prevent the regressive influence that a traditional institutional mentality or clinical elite can exert, even after institutions have been downsized or even closed, causing a loss of momentum and transformative culture. This can often result in a return to stasis once the project is complete and the energy for reform has dissipated. We must get beyond isolated great models of best practice in the community separated by vast wastelands of poor service, but instead to achieve extensive regional roll-outs on an equitable and sustainable basis of reform, protected by permanent commissions or boards (Rosen et al. 2010b). The latter, by continuing to evolve, may withstand changes of governments and political flavors; monitor the quality of services; advocate and report to the highest level of governments, legislatures, and the public; and manage to earn and retain the trust of consumers, families, and the community.

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Part VII

Applied Public Health: Special Populations

Homelessness and Behavioral Health in the New Century

33

Hunter L. McQuistion

The existence of behavioral health problems among contemporary homeless populations has led to the creation of an enormous body of knowledge and experience in service built over 3 decades. And importantly, work with people who are homeless has also offered important contributions to mainstream mental health and chemical dependency services. For these reasons it is appropriate to periodically assess the status of services for people with homelessness. This chapter describes the nature and causes of contemporary homelessness, outlines the current landscape of services, considers intertwining trends in behavioral health care, suggests a model to help direct workers as they practice and employ techniques to solve homelessness on an individual level, and offers useful interventions, both evidence-based and promising.

Contemporary Homelessness

Epidemiology

In 2010, it was estimated that 649,917 people were homeless on a given January night (U.S. Department of Housing and Urban Development 2011): no decrease since the current epoch of American homelessness emerged over 30 years ago. Although absolute numbers of homeless individuals today may not approach those during the Great Depression,[1] it has been reliably estimated that 7,000,000 Americans, or 3% of the population, will have at least one episode of homelessness during the past 5 years of their lives (Culhane et al. 1994; Link et al. 1994). As a comparison to Western Europe, one study has shown that lifetime homeless prevalence rates in the United States are comparable to those in the United Kingdom, but almost twice those found in Belgium, Germany, and Italy (Toro et al. 2007).

As of 2011, national population trends reveal some disturbing developments. For example, the number of homeless persons in families has increased by 20% between 2007 and 2010 (U.S. Department of Housing and Urban Development, 2011) and the prevalence of chemical misuse among homeless single adults has also been steadily increasing (North et al. 2004). Regarding chemical misuse, Fazel and colleagues' recent rigorous metaregression analysis of studies

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[1]Reliable national data on homelessness prevalence during the Great Depression are not available. However, as an indication of the scope of homelessness during that era, in 1932, Chicago sheltered 20,000 men in 1 day (Levinson 2004) whereas a 2009 Chicago point-in-time count yielded a total of 6,240 sheltered and unsheltered individuals. (The 2009 City of Chicago Homeless Point in Time Count, City of Chicago Department of Family and Support Services, 2009.)

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between 1966 and 2007 from developed nations (Fazel et al. 2008) derived pooled prevalence rates among homeless individuals of 37.9% for alcohol dependence and 24.4% for drug dependence. Recent surveys of single homeless adults in different American midwestern communities have also shown a remarkably similar high prevalence of lifetime substance abuse disorders. North et al. (2004) identified rates 84 and 58% and Forney et al. (2007) uncovered rates of 77 and 55%, respectively for men and women.

Studies have fairly consistently estimated rates of mental illness in adult homeless populations of between a third and a half (Roth et al. 1985; Koegel et al. 1988; Breakey et al. 1989). Fazel et al. 2008 pooled prevalence estimates yielded psychotic disorders at rates of 12.7% (2.8–42.3%), major depression of 11.4% (0–40.9%), and personality disorders (predominantly DSM1VTR Cluster C) of 23.1% (2.2–71%).

Another subpopulation of concern is families. In 2010, 37.2% of people identified as homeless by the US Department of Housing and Urban Development were members of family units (U.S. Department of Housing and Urban Development 2011). Over the past 30 years, this has grown exponentially, worsening during the current economic downturn (U.S. Department of Housing and Urban Development 2011). The modal homeless family is headed by a single mother in her late 20s, with two children (Rog et al. 2007), and it is reported that most families have only a single and relatively brief episode of homelessness. Regardless, as discussed in the next section, preventing homelessness in families may have very long-term implications for conquering homelessness.

Basic Causes

The plight of families highlights some basic causes of homelessness. A compelling rationale for the emergence of latter-day homelessness involves macroeconomic shifts in the US economy that concern a transition from manufacturing to service economies. This began after the 1960s with a relative shift in manufacturing jobs away from most developed western countries, including the United States, to less expensive labor markets (Lee and Mather 2008). Unskilled or semi-skilled workers typically have filled these jobs, whereas service economy employment often requires higher skills. Massive job losses led to unaffordable rental payments and then landlords in poor communities forced to neglect and abandon property for want of rental income. This yielded influx of the poorest into homelessness (Culhane et al. 1996). Simultaneously, in many urban centers dilapidated housing, if not laid to waste, was either gentrified or converted to commercial real estate. In New York City, it was estimated that there were 129,000 single room occupancy units in 1960, whereas by 1979, only 25,000 remained (Blackburn 1986). Hence, one unintended consequence of structural economic shifts became apparent by the beginning of the 1980s: an unrelenting explosion of homelessness exacerbating during periods of recession. The effect of increasing income disparity between the poor and affluent in the United States since the 1980s (U.S. Census Bureau 2011) also help perpetuate this phenomenon, in that groups with higher incomes drive markets, including housing (Toro et al. 2007).

Poverty is a powerful force fueling other risk factors, some of them individual in nature. Yet, these have complex interrelationships that are still not well understood. The inheritors of family homelessness are children. Children with homelessness have been documented to have higher rates of anxiety, depression, behavioral problems, developmental delays, and school performance with attendance difficulties (Bassuk 2010; Harpaz-Rotem et al. 2006). It has also been reported that one quarter of homeless children have been exposed to domestic and community-level violence (Buckner et al. 2004). It is not clear that poverty and homelessness themselves cause these childhood difficulties, rather than their being epiphenomena of related risks, such as poor health, malnutrition, parental incarceration, and substance abuse, though relationships are likely multifactorial.

There are signs of cyclic linkage within homelessness. Up to 25% of homeless children are

separated from their parents and it has been documented that one antecedent of homelessness is out of home placement during childhood (Susser et al. 1991). Additionally, findings from a national survey show lack of parental care, combined with childhood physical or sexual abuse resulted in the risk of adult homelessness increasing by a factor of 26 (Herman et al. 1997). Children in foster care, themselves at risk for homelessness, appear to have increased risk of having parents who also suffer homelessness (Zlotnick et al. 1998). Moreover, these homeless mothers may have particularly high rates of major depression and posttraumatic stress disorder compared with women in the general population (Bassuk et al. 1998). So, the thread of trauma and childhood separation cannot be ignored.

Another illustration of this complexity is chemical misuse, generally accepted to be associated with homelessness, though with unclear causal relationship. Behavioral health disorders can compromise an ability to successfully negotiate economic realities, such as rent, and it is not surprising that they tend to be overrepresented among some homeless populations. Causal covariates exist. For instance, analysis of a random probability sample in Chicago comparing literally homeless and marginally housed adults failed to link substance abuse directly to homelessness status, doing so only if there was also a lack of financial support (VanGeest and Johnson 2002).

While being mindful to not displace the deep structural effects of poverty and then "blame the victim," these traces of cultural cyclics require examination. There is renewed interest in how the effect of poverty interplays with culture (Small et al. 2010), with incipient evidence, for example, that poverty has effects on people even after they emerge from that condition (Sampson et al. 2008). It begs for ways to identify distressed families—with depressed and/or traumatized parents—so they may be supported such that events as foster care placement and/or initial episodes of homelessness can be prevented in the first place.

Therefore, it is not possible to attribute even moderately simple causation to the homeless experience. Its immediate implication is twofold. First, more finely tuned research needs to be done examining the relationship of cultural and personal risk and protective factors to homelessness. Second, multiple professional skills and resources are needed to help a person's efforts to become no longer homeless.

The Development of Services

The services that this social epidemic necessitated developed through a series of overlapping developmental phases (McQuistion et al. 2008). They evolved from a crisis-driven patchwork to elaborated systems in many urban areas offering outreach, shelter, housing, and clinical interventions. The US federal government contributed no funding until 1986 and in 1987, the landmark McKinney-Vento Act was signed, creating an ongoing funding stream for homelessness relief, prevention, and research (McKinney-Vento Act 2011). The federal government slowly moved to recognize homelessness as a fixture on the modern American scene. In 2001, it committed to encourage localities to set up 10-year plans to end chronic homelessness (National Alliance to End Homelessness 2011), a cause continued by the Obama Administration, with an additional commitment to "prevent and end homelessness among Veterans in five years; …prevent and end homelessness for families, youth, and children in ten years; and …set a path to ending all types of homelessness" (United States Interagency Council on Homelessness 2010). Local and federal agencies have issued policy briefs concerning populations with homelessness and behavioral health disorders. In 2004, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) issued its Blueprint for Change (Center for Mental Health Services 2003), outlining best practices for localities to set up services for people with homelessness and psychiatric disorders.

In this context, there have been consistent efforts to refine services based on increasingly rigorous epidemiological studies and services research. Given adequate community resources, successful movement out of homelessness is an

attainable goal for most people. In fact, most episodes of homelessness are brief and one-time (United States Interagency Council on Homelessness 2010). However, there are subpopulations with increased risk of repeated or chronic homelessness; among them are people with behavioral health disabilities.

To help address this, greater emphasis on outcomes has encouraged the development of evidence-based practices (EBPs) specifically focused on homelessness and mental illness, as well as attempts to adapt other evidence-based interventions for non-homeless populations to people who are homeless. This remains a work in progress and EBPs are complemented by promising interventions as well as day-to-day work guided by time-honored principles of service delivery to homeless populations. As all these techniques evolve, it is useful to employ a frame, or methodology, in which they may be placed. The next section describes a clinical compass for working with people with homelessness and behavioral health disorders. It provides a basis for subsequent description of the status of evidence-based and promising practices and how they can aid individual-level clinical work with people who are homeless and have mental illness and/or chemical misuse.

A Compass for Work with Homeless People

A psychotherapeutic maxim dictates that the timing of an intervention is everything. In the same vein, in order for community psychiatrists and other professionals to confidently employ behavior with people who are homeless and have behavioral health problems, it is useful to have a structure in doing so that reflects an understanding of where a person is in his or her trajectory leading out of homelessness. The resultant approach must necessarily be recovery-oriented or "person-centered." Person-centeredness focuses on the recognition that specific therapeutic interventions and services "must be constructed to meet the needs of individuals and that individuals should not be expected to benefit from programs or treatments designed for stereotypic patients with preconceived needs" (Chap. 7, page 84, lines 432–433). People are constantly developing in terms of their needs and goals. Any responsive clinical approach must be keen on this in order to foster change and improve outcomes.

This is particularly relevant to very distressed populations such as people who are homeless because of the intense social challenges they face in entering the mainstream. From an experiential point of view, a key aspect of this is the disaffiliation, or alienation and lack of social supports, experienced by many, particularly those with chronic or recurrent homelessness. This frequently presents an at least initial formidable barrier to raising hope and clinical collaboration.

A Phasic Model

To address this, the model advanced offers a phase-like transit through the condition of homelessness for those with behavioral health problems (McQuistion 2007). It incorporates three complementary dimensions, two of which specifically focus on the person's internal state, providing context for a third dimension that describes the behaviors of workers as they keep in step with the lives they serve. These dimensional phases are schematically described in Fig. 33.1.

First Dimension: Stages of Change

Concerning a person's internal state, the first of two dimensions is borrowed from the substance abuse culture. Prochaska and DiClemente's (1992) transtheoretical model describes *stages of change* that represent a continuum of psychological states referring to relative readiness for behavioral change over the course of a person's healing process, spanning a "precontemplation" of problematic behaviors progressing through "relapse prevention." While clearly applicable to chemical dependency, it may be argued that these stages of readiness can also be applied to the acceptance of, and readiness to, managing mental illnesses. It is usual for a person to shift among stages and

1 Stage of Change (Biopsychological)	2 Recovery Dimension (Existential and Social)	3 Clinical Dimension (Interventional)
Precontemplation	Dependent/Unaware	Engagement
Contemplation	Dependent/Aware	
Preparation		Intensive Care
Action		
Maintenance	Independent/Aware	Ongoing Rehabilitation
Relapse Prevention	Interdependent/Aware	

Fig. 33.1 Phasic model of work with homelessness (McQuistion et al. 2007; Prochaska et al. 1992; Townsend et al. 2000)

in that sense, smooth progression is not an expectation. Nevertheless, service interventions may be calibrated according to a person's stage of change—for example, ranging from psychoeducation or simple questions about lifestyle during "precontemplation" to the placement of self-help and other self-generated supports during "relapse prevention" at the other end of the continuum.

Second Dimension: Recovery

A second parallel dimension describes an important aspect of *personal recovery*. It embraces an odyssey beyond the illness context denoted by the transtheoretical model. Thus, it alludes to a purely existential journey embraced by the mental health recovery paradigm. The broad and complex issues lying within the recovery paradigm are beyond the scope of this chapter (see Chap. 7 for a detailed discussion) but it may be asserted that recovery is a process that is paradoxically both nonlinear and experiential, yet has features that connote a certain developmental progression as a person. Townsend et al. (2000) presented important aspects of recovery in a stage-wise framework, focusing also on aspects of social inclusion or connectedness (Aron et al. 1992). Their characterization described movement from a "dependent and unaware" state to a fully socially integrated position within the community. In a dependent and unaware state, a person is surviving but has little awareness of how he or she is dependent on formal social institutions (e.g., shelters, jails, hospitals) to manage on a day-to-basis. In this sense, he or she may suffer from the quintessential homeless experience of disaffiliation. From that point forward, there is a development of heightened realization of personal challenges, for example mental illness and/or substance abuse and awareness of dependency on social institutions. This proceeds to increasing independence on these institutions, and finally a sense of interdependence, representing a point of personal development marked by optimal understanding of self and how one depends on others and vice versa to optimize success in personal goal setting and problem-solving within the reality frame of societal opportunities and barriers.

Third Dimension: Clinical Behavior

After appreciating the phasic aspects of readiness for change in regard to psychiatric illness and then in personal recovery, clinicians are able to synchronize interventions accordingly. The third dimension therefore defines stages of *clinical behavior* within the two preceding parallel processes (McQuistion and Gillig 2006). This dimension may be applied to many populations with serious psychiatric disorders, but those who are homeless present particular need for this

systematic approach because of their frequent complexity of problems that require high levels of teamwork and timing of intervention, along with the especially salient challenge of establishing and maintaining therapeutic engagement.

Engagement

The clinician starts with a simple encounter and starts to build engagement, frequently just through small talk, in which he or she begins to encourage hope, forming a foundation of a helping and coequal relationship with a person. Engagement often occurs in shelters and public spaces, but can also occur when a person is "in-reached" by a worker during a hospitalization or if incarcerated. Because clinicians often actually initiate contact, it is important to underscore that behavioral health care is usually a low priority for the person, in contradistinction to daily survival practicalities. The clinician therefore focuses on a person's manifest or declared survival needs and builds trust. Embracing harm reduction is particularly important in this stage and motivational interviewing techniques, useful throughout all stages of care, are keys to success. The eventual engaged relationship develops and serves both of them through the vicissitudes of the next stage, called Intensive Care.

Forming and keeping relationships with people with homelessness, particularly those with mental illness and/or chemical dependency, is notoriously labor-intensive, requiring patience, respect for privacy, and care with coercive interventions. The latter deserves special comment in that clinicians, most commonly in street outreach, must sometimes employ involuntary measures, such as transport to an emergency room when there is evidence of acute danger to self or others. This is determined on a case-by-case and encounter-by-encounter basis, bearing in mind the following important evaluative factors: (1) the rapidity of physical or psychiatric deterioration; (2) the opportunities for subsequent observations and assessment; (3) the degree to which there is an established relationship with the person in order to negotiate voluntary interventions, even in the state of higher risk to self or others. Care with this is important because, as noted above, there is evidence of high rates of physical and sexual traumata in the histories of homeless people, particularly those with mental illness and substance abuse (Christensen et al. 2005), coupled with the sense of trauma often associated with involuntary measures, whether police/emergency medical service transport, in emergency room settings, or on inpatient units.

Intensive Care

If there is successful engagement, clinical intervention transitions to a higher level of activity, termed Intensive Care; one that is by definition more demanding for the person being served, as well as for clinicians involved. However, the sequencing and intensity of activity is also determined by the person's individual goals and needs. Housing is often the touchstone and accessing it can include layers of treatment for mental health, chemical dependency, and medical illness, the securing of benefits, and the beginnings of vocational/educational rehabilitation. The team of people working with the person consequently expands and can include housing specialists, vocational/educational counselors, social workers, primary care clinicians, and community psychiatrists. Psychiatrists most typically become involved during this stage, themselves engaging with potential patients. Working with people who are homeless involves tolerating a great deal of ambiguity in terms of treatment planning, tolerance of risk, or interrupted service. Intensive care carries high risk of retrogression, in part because of heightened rehabilitative demands experienced by the person in tandem with countertransference risks of multiple providers, who for example might either experience unrealistic expectations in the context of a person's stage of change and personal recovery goals, or relative inactivity, identifying with hopelessness or under-estimating his/her need for support and thereby inadvertently sending a message of being uninterested, reinforcing disaffiliation. Because of the breadth of training in psychiatry, including in psychotherapeutic and systems-based competencies (Accreditation Council for Graduate Medical Education 2011), there is particular opportunity during this stage for community psychiatrists to exercise a role in clinical team leading and systems-level advocacy, using a full range of biopsychosocial skills to help

coordinate interventions and support the expertise of other team members in a manner that is sensitive to the person's needs and goals.

Ongoing Rehabilitation

Intensive Care segues to an open-ended third stage of Ongoing Rehabilitation that, especially in its progression over time, more closely resembles working with never-homeless populations. This stage synchronizes with movement toward "interdependence," in Townsend's characterization and relates to Proschaska and DiClemente's "relapse prevention" and "maintenance." During this stage, a person gradually sheds an identity of homelessness, continuing to pursue personal recovery goals, broadly speaking in work and love. By now, people nearly always are housed, may be pursuing work or vocational/educational rehabilitation, and may be reestablishing meaningful ties with family, forming permanent relationships, and for some, pursuing broader social and/or spiritual concerns, including affiliating with faith-based organizations and other community institutions. While always collaborative, the community psychiatrist shifts role during this stage to even more of a coaching stance in that a person's recovery has further evolved and he or she is managing life with increasing personal agency. Part of this role is to work hard with the person to help in psychoeducation and in psychotherapy to be aware of new stresses that can precipitate illness exacerbation or relapse to chemical misuse, perhaps even threatening housing stability. Though not as intensively, the community psychiatrist continues with active systems coordination and advocacy, always bearing in mind an entropic tendency within service networks. This further prevents suboptimal outcomes.

Some Key Principles

Augmenting this methodology are some basic service principles articulated over the past 3 decades. They include the following watchwords (Osher 2001; Substance Abuse and Mental Health Services Administration in development) also listed in Table 33.1.

Table 33.1 Key principles in clinical work with homeless populations

Access housing: the first order of business
Enable income stability: employment or federal disability insurance without delay
Be active, persistent, yet flexible: trust is hard-won and respect is necessary
Maintain optimism and think longitudinally: culture the relationship, be a real object, setbacks are natural
Connect to natural support network: extended family, peer supports, community institutions
Focus on cultural competence: ethnicity, race, gender, sexual orientation affect the experience of homelessness
Integrate services: teamwork and careful attention to biopsychosocial complexity

Housing access as bulwark: Although achieving housing stability for people with behavioral health disorders requires more than housing itself, without permanent housing, a solution to homelessness is obviously impossible. This indispensable resource is discussed in detail in Chap. 29.

Income stability as key: In order to manage day-to-day living, there must be a stable source of income. For example, public assistance is notoriously unstable (Zlotnick and Robertson 1999) and research indicates more housing instability with this income mode. If eligible and unable to return immediately to work, the use of federal disability insurance is frequently the best springboard to financial stability. This benefit is critically evaluated in an ongoing manner as people ready themselves for work.

Using active, persistent, yet flexible techniques: As noted, clinical behavior must be flexible but also patiently assertive. Trust is hard-won, especially with those who have had lifelong exposure to the criminal justice and human services systems, and childhood experience with domestic violence or other traumata.

Being optimistic and having a longitudinal perspective: The road from homelessness can be a very long one with setbacks and rewards. In pursuit of maintaining mutual respect and

engagement—and the building of a personal agency—clear acceptance of even apparent poor judgment is part of respect, understanding that people remain in recovery, regardless. Countertransference urges to be overly assertive or coercive to gain rapid results can yield loss of engagement. However, many believe that it remains ethical to use the leverage that emerges within a clearly helping relationship, as long as respect and choice is continuously communicated. Examples range from a person accepting a recommendation for treatment born from recognizing a psychiatrist's technical expertise to accepting limits on behaviors affecting a community (e.g., using substances on shelter premises) because of perceived gains in not endangering a collaborative relationship. The reciprocity implied in this process helps weather other transference-countertransference events and assists a clinician in advocating for and supporting the patient when there are stressors to clinical stability.

Using natural support networks: When possible, it is important to reach out to extended family, develop peer support, and link people with community institutions, such as faith-based organizations, counters disaffiliation. This support may be particularly helpful to prevent a recurrence of homelessness when adults live with family.

Focusing on cultural competence: Please see Chap. 15 for a detailed discussion of cultural competence. Historically, there has been relatively little attention focused on the causes and effects of culture among homeless populations (Gamst et al. 2006) while, in 2010, 37% of sheltered homeless persons were Black, 16.4% Latino, and 41.6% White and non-Hispanic (U.S. Department of Housing and Urban Development 2011). Among homeless youth, up to 20–40% may identify as gay, lesbian, bisexual, or transgender (Ray 2006). These facts demand that community psychiatrists adopt clinical behavior, implement program interventions, and encourage diverse staffing that address cultural issues that might erode engagement among homeless populations (Whaley 2001).

Integrating services: Because complexity—social, psychological, vocational, chemical dependency, medical—is routinely encountered in persons with homelessness, it is an absolute requirement that effective care be integrated. As noted in the discussion of stages of clinical care, teamwork is a key—with communication that is regular, methodical, and noncrisis driven. This is often viewed as laborious, but it is a truism that tight clinical communication minimizes poor outcomes and it is a major tool for successful engagement, establishing optimal collaboration with the person struggling to emerge from homelessness and ultimately yielding high rewards for clinicians, too.

Evidence-Based and Promising Practices

Some interventions have accumulated sufficient data as to be recognized EBPs. A few have been developed specifically for homeless populations with mental illnesses while others have found adaptation to homeless persons. Still other practices, primarily achieving expert consensus in effectiveness or showing promise to do so, are promising or emerging. This section surveys these practices as tools for clinicians within the clinical dimensional stages of Engagement, Intensive Care, and Ongoing Rehabilitation.

Evidence-Based Practices Specific to Homeless Populations

Critical Time Intervention

Critical time intervention (CTI) is an intervention specifically tailored to assist people who are homeless and have mental illnesses during transitions. First, developed in a municipal shelter setting for homeless men, its original iteration's goal was to help assure successful transition from that setting to housing (Valencia et al. 1996). The intervention's evidence base is primarily derived from an adult homeless sample (Susser et al. 1997) and is being applied to veteran subpopulations, homeless families headed by young single

mothers, and as a mechanism for movement from relatively costly assertive community treatment (ACT) teams to less intensive services (Critical Time Intervention 2011). Among homeless adults, it also shows evidence of decreased negative symptoms in schizophrenia (Herman et al. 2000), and cost-effectiveness (Jones et al. 2003).

The model hinges on case management that focuses on linkage, with workers engaging people during the "critical time" in which they are developing relationships with new providers and in new social environments. Periods of flux hold both high risk and special opportunity in that movement to housing, for example, represents a time of hope and motivation. CTI is time limited to 9 months and this has been shown to be effective, in contrast to conventional wisdom that open-ended support is optimal (Herman et al. 2007).

CTI is thus divided into three phases of decreasing intensity of service: first, with the case manager engaging with a person, acting as collaborator and advocate while evaluating individual strengths and needs while assessing community supports; then adjusting and monitoring supports as the person tries them out; and, finally, fine-tuning supportive mechanisms and cementing long-term supports, hence transferring care to involved community providers and formally marking termination (Herman et al. 2007). The process is guided by individualized service planning based on any of six areas that affect housing tenure: psychiatric treatment, housing crisis prevention and management, substance abuse treatment, life skills training, money management, and family intervention. In CTI's adaptation to young mothers, case managers' clinical supervision with a psychiatrist is also employed and viewed as particularly helpful in encouraging understanding of clients' strengths, as well as multiple challenges, such as histories of trauma and neglect (National Center on Family Homelessness 2010). In considering the tri-dimensional methodology described above, CTI often initiates in the earliest precontemplation/dependent unaware/engagement stages, and most logically begins to terminate through a later dependent aware/action/intensive care stage as a person may reunite with family and transition to a range of community providers who address a potential array of complex needs. So, while CTI addresses the practical challenge of housing stability, it also helps in a process of social connectedness by actively prioritizing the establishment and renewal of relationships, both services-related and personal.

Pathways to Housing

The "housing first" model was pioneered by Pathways to Housing (2011) and it is described in detail in Chap. 29. In the realm of housing literature, which suffers from significant methodological issues (Rog 2004; Fakhoury et al. 2002), it is important to state here that this model has provided evidence of effectiveness when compared to the more traditional methods that have existed for many years. These models rely on loose criteria of "housing readiness" and concentrate on a gradual movement of people, for example, from the streets, to drop in centers of shelters, then to housing.

Pathways' technique, conversely, offers housing to people as soon as benefits or other means for rent have been obtained. A key element is combining the offer with an ACT team that flexibly supplies a range of treatment and rehabilitation supports—in a person's new home, if necessary. A prospective random assignment study showed 79% retention in Pathways, as opposed to 27% for traditional controls (Tsemberis et al. 2003). Because of its use of ACT, the Pathways to Housing model has capacity to serve people through clinical dimension stages of Engagement, Intensive Care, and only terminating at the point of Ongoing Rehabilitation, when a person is at least independent/aware and in action to relapse prevention or maintenance stages.

Adaptations of Evidence-Based Practices to Homeless Populations

Assertive Community Treatment

Please see Chap. 24 for a description of ACT. ACT's approach of mobile and comprehensive

community-based care and case management for people with serious psychiatric disorders and its proactive and continuous approach fits needed services for people with homelessness and mental illnesses, given additional complexities that include housing needs, income support, substance abuse, and medical problems. In general populations ACT has been shown variably to improve rates in emergency department visits, in psychiatric inpatient days, in substance use, quality of life, employment, and psychiatric symptoms (Lehman et al. 1997; Philips et al. 2001; Substance Abuse and Mental Health Services Administration 2003; Drake et al. 2004). ACT's flexibility enables it to be implemented during the stages of precontemplation/dependent-unaware/Engagement and flexibly move though the clinical stage of Intensive Care, transitioning away as a person roughly reaches stages of relapse prevention/independent-aware/ongoing rehabilitation. ACT has been adapted to homeless populations for over 20 years, with evidence of improved housing stability (Morse et al. 1992, 1997). Often desirable are program modifications more closely meeting homeless consumer needs including creating a drop-in environment; subdividing the team into mini-teams to improve engagement capacities; the imposing time-limited service to permit transition to less intensive and care; and hiring consumer advocates to diminish stigma within the team and a family outreach coordinator to help rebuild relationships (Hackman and Dixon 2006).

Psychopharmacology

As in any endeavor involving the prescription of medication, the greatest skill is not how to choose a pharmacological agent, but when and how to present it. People with homelessness and mental illnesses often pose dramatic challenges to introducing and maintaining adherence to medication. Disaffiliation adds an additional layer on any psychopathological issue affecting trust. Community psychiatrists, working with the clinical team, may work with potential patients in the stage of Engagement but, as noted above, deliver their bulk of energy during Intensive Care. In this stage, the role of medication is typically discovered over time, revealing a rationale for its use, such as being a tool for people to take full advantage of their own strengths, or accentuating medication's potential to "take the edge off" of emotional pain. Dosages are titrated flexibly and, commonly, once-a-day regimens are relied on to optimize adherence. In all, psychiatric work with homeless persons has greatly contributed to the art of—or better described, *competence in*—sensitively tuning to a person's stage of change as it is relevant to medication interest. By blazing trails outside of traditional clinical settings, community psychiatrists have helped transform this technique from paternalistic to collaborative and patient-centered. The following vignette illustrates this.

> Roberto is single and had two prior hospitalizations several years ago via "911" calls by family but without adherence to psychiatric follow-up. He was homeless for six months after being ejected from his sister's apartment upon losing his job as a foot messenger. First living in the street and on the subways, he eventually found his way to the city's shelter system. He was disheveled, edgy, presented evidence of auditory hallucinations, and felt unsafe because people were spying on him in the context of law enforcement work he says he was secretly involved in. Shelter staff engaged with him by offering fresh clothes and help with housing, and after several weeks agreed to see a psychiatrist to help with his sense of anxiety. After a number of meetings, some of them brief and with small talk, but also with the psychiatrist particularly expressing interest in his family (who he missed, despite what he described as his "important work"), Roberto considered medication to help him feel less stressed by the distracting voices that said bad things about him and were connected with the people spying on him. Over a weekend, just before an appointment in which a prescription was to be written, Roberto had an argument with a fellow client and left the shelter. The team lost track of his whereabouts until he returned about two months later. He described staying in the subway for about a week but then went to an emergency room asking for medication for the voices. He was admitted and placed on an antipsychotic medication. While still with some delusional ideas, the hallucinations were gone and in meeting with the team, agreed to continue the regimen.

Shelter clinical staff laid groundwork through interest in Roberto's life (not his symptoms) and although hospitalization occurred, it was salutary in that a rationale had been accepted to the point

where he presented voluntarily to an emergency room for medication, with willingness to return to the shelter, and movement along the process toward stages of awareness-dependency/action/intensive care. In this way, even lapses in treatment with people with mental illness and homelessness can mark success.

Employment and Education: Supported and Transitional

Supported employment, such as individual placement and support (IPS) (see Chap. 25), and transitional employment (see Chap. 30) are EBPs that have gained wide recognition in general populations with serious psychiatric disorders, many of whom might have had histories of homelessness. Purposeful vocational or educational rehabilitation most frequently begins toward the end of Intensive Care or during Ongoing Rehabilitation. Because work is both practical and is a frequent instrument of self-esteem is, more efforts must be expanded to offer vocational or educational rehabilitation opportunities to people who are recently housed or still homeless. The highly egalitarian and supportive environments of psychosocial clubhouses may especially offer advantages to diminish disaffiliation among its members who are homeless, fostering social connectedness.

Interventions for Co-occurring Disorders

Clinicians recognize rates of co-occurring mental illness and chemical dependency are elevated among people who are homeless, with estimates in the literature have been as high as 85% (Joseph and Langrod 2004). This reality helped inspire efforts to develop interventions for these co-occurring disorders for all clinical populations. The development and practice of this field in community psychiatry is also detailed in Chap. 23.

Continuous and comprehensive integrated systems of care (CCISC). CCISC presents a remarkably comprehensive set of interventions. At its core is a philosophy that rejects the historic separation of mental health and substance abuse treatment, instead considering a person-centered approach. It also focuses on systems-level change, along with the use of existing resources, and incorporation of best practices (Minkoff and Cline 2004; Drake et al. 2001). Studies of CCISC with people with homelessness have shown significant improvements in housing, mental health, substance abuse, and employment (Harrison et al. 2008; Moore et al. 2009).

Modified therapeutic communities (MTCs). As another model focusing on co-occurring disorders, MTCs offer an intervention that is grounded in Intensive Care (action/dependent-aware) and has been shown to be effective in homeless populations (Sacks et al. 2008), with improved measures of abstinence, psychiatric symptoms, and housing. Compared with classic therapeutic communities, MTCs are less confrontational and incorporate treatment for mental illnesses. However, gains can be lost without continuous aftercare, resulting in high relapse rates and setbacks in a progress to Ongoing Rehabilitation (maintenance/independent-aware, maintenance/interdependent-aware). One MTC evidenced comparably less chemical misuse and greater housing stability with inclusion of aftercare groups and case management, supporting sobriety, and creating a bridge to the community while building on social connectedness established in the MTC (Sacks et al. 2003).

Promising Practices

Outreach Models

Outreach is the quintessential practice in work with homeless populations, primarily practiced in public spaces and shelter settings. Successful outreach hinges on offering people what they manifestly need: food, clothing, shelter, housing. Through this, engagement begins. This process can take from weeks to many months. The reasons are several but involve the fact that until recently outreach technique, as well as outreach teams' actual ability to access services, have received relatively little professional and policy attention (Ng and McQuistion 2004). In some localities, primarily through the impetus of 10-year Plans to End Chronic Homelessness (McKinney-Vento Act 2011), policymakers have now purposefully linked street outreach to

measurable outcomes (Common Ground, Inc. 2011) when coupled with connection to available housing or hostel/shelter environments. Because outreach is time consuming, cost tends to limit the use of community psychiatrists in street-level outreach, except in the role of mobile crisis in which involuntary transport to an emergency room is required to maintain safety (usually severe physical self-neglect or behavior such as walking in traffic). However, psychiatrists have a role in clinical consultation and supervision, particularly in regard to helping staff understand psychopathology and medical issues, and assisting in estimating risk.

The Use of Peers

In the 1980s, prescient homelessness outreach programs pioneered the utilization of peer workers, formerly homeless people often in recovery from addictive disorders, to lend greater effectiveness to engaging people. Peer workers reinforce hope, are role models, enhance credibility, and offer day-to-day education for professional staff about a culture many have only glimpsed. In addition to street outreach, peer counselors have been used in a variety of settings throughout the stages of clinical care, for example in working with homeless youth, in veteran populations as case managers, on homeless ACT teams (Dixon et al. 1997), with adults with mental illnesses and forensic histories (Rotter et al. 2005), and, of course, in therapeutic communities. Peer counseling and advocacy is an advancing area in all of behavioral health (see Chap. 10), and the role of peer workers continues to evolve through active discussion and investigation within the field (Gates and Akabas 2007)

Abstinence Contingent Housing

Contingency management is a clinical application of behavior modification in which tangible rewards are offered for behavior, such as chemical use abstinence (Higgins and Petry 1997). The technique tangibly rewards people for adherence to program rules. Milby and colleagues have developed abstinence contingent housing programming with evidence of effectiveness for people with co-occurring nonpsychotic Axis I mental illnesses (Milby et al. 2003). Shelter outreach workers recruit people who express readiness to consider not using drugs and alcohol to enter day treatment and, if with negative urine toxicology tests, access supportive housing. If testing lapses positive, immediate return to shelter occurs (while maintaining day treatment) until the next negative test, at which point housing is immediately re-accessed. This technique holds promise for flexibly working through stages of change with people struggling with substance use as they seek housing.

Trauma-Informed Services and Treatment

Techniques concerning trauma may be divided into trauma-informed services and interventions specifically focused on treating the trauma's sequelae (see Chap. 12 for details). Trauma-informed services have been explored in homeless populations and focus on an individual's strengths to regain a sense of control and accentuate psychological and physical safety, thus preventing retraumatization (Hopper et al. 2010). Specific treatments for trauma show modest but encouraging results when applied to homeless populations with co-occurring mental illness and substance abuse (Desai et al. 2008; Morrissey et al. 2005). One of these, Seeking Safety, is known to be effective in non-homeless populations, including those with mental illnesses (Najavits 2009). Seeking Safety can be employed as either an individual or group intervention that starts by creating a sense of safety, instills hope, and integrates attention to chemical misuse with treatment for posttraumatic stress disorder, covering 25 topics that are rooted, separately or in combination, in cognitive, behavioral, or interpersonal treatment domains while also focusing on clinician processes and responses (Seeking Safety 2011).

Primary Care: Behavioral Health Integration

The integration of primary care and behavioral health services is an extension of the mandate for integrated treatment of co-occurring disorders, and it has aroused great interest in behavioral health circles, triggered in part by incentives in

the 2010 federal Affordable Care Act (see Chap. 5 for details). As of 2011, large-scale pilot programming has been initiated, even through state programs (CALMEND 2011). For very many years primary care-behavioral health integration (PCBHI) has been practiced in degrees by programs serving homeless populations. The need to serve disabled people with homelessness who frequently present with extreme clinical and social complexity has, so to speak, served as PCBHI's mother of invention. Boston Health Care for the Homeless Program's (BHCHP) medical respite service provides short-term residential medical care for people unable to manage on the streets or in shelters. In 1996, BHCHP adopted the first electronic medical record system in any homelessness services organization nationally and subsequently began to engage in research, recently in evaluating PCBHI (O'Connell et al. 2010). These and other projects, residing in community-based services organizations, provide models on which to build. Next steps must include dissemination of effectiveness data that can be used to advance further innovation.

Conclusion: The Way Ahead

History unfolds and while there is no current sense of an ending to homelessness in America there is at least recognition of its gravity, with efforts to make macro-level inroads. In the next developmental phase, prevention research must be at the forefront, exploring the interplay of the structural economic issues with personal risks and resiliencies so policymakers and program planners may design social interventions.

To help accomplish this, and to encourage needed services to manage here-and-now homelessness, advocacy remains crucial. The apparent permanence of homelessness may discourage sustained efforts in this regard. However, in addition to the daily advocacy in which community psychiatrists unflaggingly engage as they work with patients who are homelessness, such as in helping with entitlements, in accessing people to medication grant programs, and in connecting them to primary care, the scope and stigma of homelessness require organizational energy—both grassroots and professional. They have slightly differing roles: grassroots governmental lobbying, advocating "from without," and among professionals, to improve awareness "within" through education, primarily to decrease the multiple stigmata, whether behavioral, forensic, or economic, that surrounds homelessness. Yet another educational mechanism of advocacy embodies training through sponsoring, supervising, or creating experiences with homeless populations for medical students and residents.

What will also help advance funding is to show evidence of effectiveness. The incorporation of continuous quality improvement (CQI) methods (see Chap. 45) has been relatively slow to penetrate homelessness services programs. The reasons for this are various but may include relative lack of regulatory oversight, modest government contractual funding that has never required CQI, and the historical fact that until recently there have been few evidence-based interventions. However, CQI enables the generation of "practice-based evidence" through the testing and refining of outcome hypotheses within creative programming.

Finally, there is the quest for services integration. While respecting personal privacy, integrating electronic records and databases goes a step toward communication and coordination. The use of regular interdisciplinary and inter-programmatic in-person or electronically based case conferencing and service planning will also help effectiveness. Funding agencies have the important role of creating incentives for this by financing organized service networks or consortia that share time, resources, and successful outcomes.

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34 Criminal Justice: Promoting Public Health and Public Safety

Fred C. Osher

I am dismayed to be "forced to authorize the confinement of persons with mental illness in the Williamsburg jail, against both my conscience and the law" because of lack of appropriate services

(Deutsch 1937).

Introduction and Background

Persons with mental illnesses are vastly overrepresented in the criminal justice system—from arrest to reentry from jails and prisons. Researchers have documented serious mental illnesses in 14.5% of male jail inmates and 31% of female jail inmates (Steadman et al. 2009); rates in excess of 3–6 times those found in the general population (Kessler et al. 1996). Generalized to the findings that over 13 million jail admissions were reported in 2009 (Minton 2010), this implies that over two million bookings of a person with a serious mental illness occur annually. The presence of so many people with mental illnesses in criminal justice settings represent an enormous burden on federal and state corrections and behavioral health systems of care, our communities, families, and those with mental illnesses. There are multiple factors that contribute to this phenomenon, but none that can justify the tragic circumstance of imprisoning someone when effective treatment options are possible alternatives.

The majority of individuals with mental illnesses who wind up in jails have committed nonviolent misdemeanors, often as a result of their untreated mental illnesses. That said, it is important to be mindful that having a mental illness is not a "free pass" for criminal responsibility and people with mental illnesses will commit crimes for which legal remedies are appropriate and essential (JLI, Judges' Criminal Justice Mental Health Leadership Initiative 2010). Persons with mental illnesses who commit crimes must be held responsible for their actions, but the effect of the illness on behavior must be taken into account.

For individuals with mental illnesses, contact with the criminal justice system starts a cycle of arrest, incarceration, release, and rearrest that can pose nearly insurmountable challenges to recovery. With more serious charges, or failure to comply with conditions of probation and parole, prisons become the institutional home for these individuals. However, most criminal justice personnel agree with community-based treatment providers that jail and prison environments are not the best setting for individuals with mental illnesses.

This chapter focuses on the collaborative activities between mental health and criminal justice systems that are necessary to reduce the prevalence of persons with mental illnesses in the criminal justice system. As such, it is not a discussion of traditional forensic psychiatry with its rich history in civil law, criminal evaluations, and expert testimony. Rather the focus of this chapter is on the factors that increase risk of incarceration for persons with mental illnesses and the role of community psychiatry in achieving positive public health and public safety outcomes for these justice-involved individuals.

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The incarceration of high numbers of persons with mental illnesses is taking place in the context of expanding incarcerated populations in general. Over the past 25 years, the nation's prison and jail population has skyrocketed to an all-time high, with over two million people incarcerated and over five million on some form of correctional supervision. The United States reached the dubious landmark of having over one in every 100 adults in the nation behind bars (Pew Center on the States 2008). The United States has just 5% of the world's population, but accounts for 23% of the world's prisoners (Pew Center on the States 2008). Beyond the human cost, correctional spending has soared over the last 20 years to keep pace with rising prison populations. Annual state spending on corrections has grown 137% and is now over $50 billion (National Association of State Budget Officers 2009). Only Medicaid has grown faster than corrections as a proportion of state spending (National Association of State Budget Officers 2009). Reducing the number of persons with mental illnesses under correctional supervision will reduce costs and is a shared goal for behavioral health and criminal justice systems.

While these numbers cry out for new ways of doing business, it is imperative that community providers appreciate their role in enhancing public safety and commit to using behavioral health interventions to achieve positive public safety outcomes. Towards this end, the Group for the Advancement of Psychiatry Committee on Community (2010) has articulated the following principle:

> Public safety is part of the mission, priority, and concern of community psychiatrists and community behavioral health systems; community behavioral health and criminal justice service providers are partners in public safety and public health. Effective responses to justice-involved populations require collaboration and partnership with multiple systems.

It is also the case that involvement in the criminal justice system can be a public health opportunity. Jails and prisons are obligated to provide general and mental health care (Cohen 2003; New Freedom Commission on Mental Health 2004) in addition to meeting detainees' other needs. In fact, incarcerated individuals are the only U.S. citizens with constitutionally protected access to health care. The US Supreme Court, in *Estelle v. Gamble* [*429 U.S. 97* (*1976*)] found that deliberate indifference to prisoners with "serious medical needs" constitutes a violation of the eighth Amendment of the US Constitution. In *Estelle v. Ruiz* [503 F. Supp. 1265 (S.D. Tex. 1980)] and subsequent cases, "serious medical needs" were extended to include mental illness by the Fifth Circuit. The American Psychiatric Association (2000), the National Commission on Correctional Health Care (2008), and the National Institute of Correction (Hills et al. 2004) have all recommended that all jails provide at minimum: (a) mental health screening, referral, and evaluation; (b) crisis intervention and short-term treatment (most often medication); and (c) discharge and prerelease planning. Of note is that all of these standards include recommendations to assure connections to needed treatment and support services.

There have been concerted efforts by criminal justice systems to identify persons with mental illnesses at the earliest possible moments and to develop mechanisms to leverage legal authority to improve their connection to treatment. Innovative police-based responses, specialty courts, and jail, prison, and community corrections programs with a focus on persons with mental illness have been developed. The shared goal for all systems is to reduce the frequency of contacts and absolute numbers of justice-involved persons with mental illnesses in criminal justice settings. At the heart of all these strategies lies the delivery of, or linkage to, effective mental health services in the community. Police, judges, and corrections staffs that refer a person with mental illness to community-based care expect the delivery of comprehensive and effective services.

Why Are There So Many People With Mental Illnesses in Jail and Prison?

To develop appropriate responses to justice—involved persons with mental illnesses, it is important to understand the reasons why they

wind up in jail and prison. There are a number of contributing factors. First, people with mental illnesses are at increased risk of developing substance use disorders over the course of their lifetimes, and arrests for drug offenses have skyrocketed since 1980 (Mauer and King 2007). Rates of incarceration are generally higher for persons with co-occurring disorders compared with those with only mental illness (Mueser et al. 2001). Research has found that nearly three-quarters of men and women with mental illnesses in jails also have a co-occurring substance use disorder (Abram and Teplin 1991). High rates of illegal substance use leads to high arrest rates.

Second, incarcerated persons with mental illnesses are much more likely to have been homeless at the time of their arrest than those without mental illnesses (Ditton 1999). In jails, 30.3% of inmates with mental illnesses were homeless in the year prior to arrest compared to 17.3% of other inmates (Stephen 2001). Being homeless makes a person very visible in our communities and their panhandling or public intoxication frequently result in calls to law enforcement. In addition, not having a stable place to live severely complicates the reentry of a person with mental illness following release from prison.

A third contributing factor is the harsh conditions in many jails and prisons that can have a harmful effect on the mental health of all prisoners. Overcrowded, high-intensity interactions with regular threats to personal safety and limited access to treatment can make the experience of incarceration a prolonged traumatic event. The noise levels within jail and prison settings throughout the day and night are excessive and there is absolutely nothing the inmate can do about it. And yes, this is incarceration after all, but the deleterious effects of these circumstances on person with serious mental illnesses are predictable—despair, psychotic symptoms, and violent acting-out. These reactions are exacerbated by the use of special housing units which isolate the prisoner from contact and services.

Fourth, once in jail and prison, people with mental illnesses tend to stay longer and are less likely to be placed on probation or parole, than others charged with similar offenses. Parole board members may lack confidence in community resources for individuals with mental illnesses, have misconceptions about mental illnesses, or fear negative public reactions. As a result, people with mental illnesses have their release delayed and more often serve the maximum sentence allowed by law (Council of State Governments Justice Center 2002). Fifth, once released, without adequate treatment, supports, and supervision, prisoners with mental illnesses are more likely to recidivate. Compared to their relatively healthy counterparts, probationers and parolees with mental illness are significantly more likely to have their probation term suspended or revoked (Skeem et al. 2008). In a study of people released to parole in California during 2004 (more than 100,000 people), researchers found that people on parole with mental illnesses were more likely to return to prison for a parole violation within 1 year (33%), compared to people without mental illnesses (20%) (Skeem et al. 2011).

And finally, limited access to overburdened community-based treatments makes at-risk individuals with untreated symptoms more likely to be arrested. As such, cuts in mental health services have an impact on the prevalence of mental illnesses in jails and prisons insofar as they make it more difficult for treatment providers to dedicate resources, time, and treatment slots to this population. In combination, these factors account for the high prevalence rates of mental illnesses among justice-involved persons.

One public misconception about the reason for so many people with mental illnesses in jails and prisons is the belief that persons with mental illnesses are inherently violent. It is critical to iterate that most people with mental illnesses are not violent, and most people who commit violent crimes do not have mental illnesses. It is the case that those people with mental illnesses who are violent often have untreated symptoms of psychosis and/or co-occurring substance use disorders, with stimulant abuse being particularly problematic (Miles et al. 2003). It is also the case that people with mental illnesses are far more likely to be the victims of crime than perpetrators (Teplin et al. 2005).

What Can Be Done to Reduce the Likelihood That They'll End Up There?

There are programmatic responses that can identify persons with mental illnesses in the criminal justice system and divert them from jail and prison, or reduce the likelihood of their return to jail and prison after incarceration. All of these programmatic efforts are dependent upon collaboration between the mental health and criminal justice systems and require linkage to effective treatment and services in the community. In this next section, we discuss innovative program models and the types of individual evidence-based practices (EBPs) that are associated with public health and public safety positive outcomes. The Sequential Intercept Model (SIM) (Munetz and Griffin 2006) creates a framework for communities to organize responses to assist justice-involved individuals with mental illnesses. The model diagrams the various stages at which an individual may come in contact with the criminal justice system. The five intercept points identified in the model are: (1) law enforcement; (2) initial detention and hearings; (3) jails/courts; (4) reentry from jail or prison; and (5) community corrections (Fig. 34.1).

A sixth and "ultimate" intercept has been posited: access to comprehensive and effective community-based services. This intercept will be discussed in the context of EBPs that target risk factors for criminal justice involvement.

The broad set of responses to behavioral needs of citizens within a community is shaped by local, state, and federal regulations and policy. When this focus is narrowed to a specific target population defined by its participation in criminal activity, the need to incorporate the perspectives of law enforcement, courts, and local and state corrections personnel is imperative. Clarity in the goals and objectives for initiatives is critical to determine the range and intensity of collaborative partnerships. At the outset, stakeholders may be convened as a strategic planning committee, but additional collaborative partners will emerge as goals are explicitly stated. Additional partners may include health and hospital providers, housing officials, private funders, elected officials, crime victims, and community representatives. While concerns about issues related to the over-representation of persons with mental illness in the criminal justice system may be raised by any group, responses will need the committed leadership of mental health and substance abuse providers.

The SIM focuses on a series of intercepts where interventions can be set up in order to prevent individuals from penetrating further into the criminal justice system. At each of these intercept points on the SIM, there is an opportunity to develop programs that are tailored to the needs of persons with mental illnesses. The earlier in the SIM that a person can be redirected, the fewer legal consequences they will encounter that can block their path to recovery. At the first three intercepts, the processes are referred to as jail diversion which is defined as:

> A community-based, collaborative criminal justice-mental health response for justice-involved people with mental illnesses where jail time is reduced or avoided, and the individual is linked to comprehensive and appropriate services (JLI, Judges' Criminal Justice Mental Health Leadership Initiative 2010).

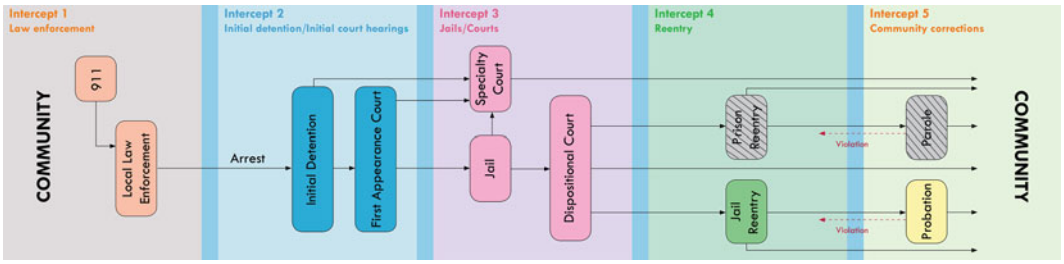

Fig. 34.1 Sequential intercept model (GAINS 2009)

Police-Based Responses

The earliest and most prevalent prebooking diversion programs rely on trained law enforcement officers who interact with people with mental illness in crisis. Law enforcement officers are the first-line, around-the-clock responders to deal with persons with mental health emergencies or criminal activity. How law enforcement personnel react to these individuals can have a huge impact on their outcomes and determine whether a person is linked to treatment or enter the criminal justice system. Specialized police-based responses (SPRs) have been developed around the country (Schwarzfeld et al. 2008). The most recognized SPR is the Crisis Intervention Team (CIT), as developed in Memphis, Tennessee, where officers receive extensive training in how to recognize behavioral disorders and deescalate the crisis on-site. Another type of SPR relies on mental health specialists who are hired to provide consultation to police officers. A third prebooking SPR approach is a specialized community mental health response, which includes a mental health mobile crisis team that responds upon request from law enforcement. SPRs have been associated with decreased injuries to officers (Reuland 2004) and increased linkage to mental health treatment (Steadman and Naples 2005).

Jail- and Court-Based Strategies

Postbooking diversion programs at Intercept 2 involve jail-based and court-based strategies. In these programs, individuals are screened and identified as having mental health needs and linked to treatment with conditions of release related to their charges. These interventions may consist of teams of mental health providers that operate within the jail and are available to assess individuals after arrest and advise the court or attorneys as to the appropriateness of deferred prosecutions, bond levels, and alternative dispositions in the community. Identification of arrested persons with mental illnesses in some communities has been improved by the matching of jail rosters to public mental health rosters. A one-way flow of information is then generated to the mental health provider informing them that their client is in custody. The mental health provider can then attempt to engage their client and coordinate care within the jail and promote alternatives to incarceration.

Mental Health Courts

At intercept 3, mental health courts have been developed in hundreds of jurisdictions around the country. These courts are defined as "a specialized court docket for certain defendants with mental illnesses that substitute a problem-solving model for traditional criminal court processing." Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, nonadherence may be sanctioned, and success or graduation is defined according to predetermined criteria (Thompson et al. 2008). Mental health courts have been associated with improved linkage to services, lower rates of criminal involvement, and the potential to produce cost savings (Almquist and Dodd 2009).

Transition Planning

With the constitutional obligation to provide health care within jails and prisons comes an opportunity to identify and begin treatment for mental illnesses within those settings. Despite chronic staffing shortages and limited formularies, critical treatment takes place behind the fences. Assuring continuity from the community, to the jail or prison, and back to community is a critical component of effective mental health care and consistent with all recovery principles. Thoughtful transition planning from jails and prisons can reduce the possibility of return to criminal justice systems. Almost all jail inmates, including those with mental illnesses, will leave correctional settings and return to the community.

At intercept 4, inadequate transition planning can put individuals who entered jail in a crisis state back on the street in the middle of the same crisis. This in turn puts jail inmates at risk for repeat offenses, increased psychiatric symptoms, hospitalization, homelessness, and rearrest (Daniel 2007). We follow the suggestion of the American Association of Community Psychiatrists (AACP) by using the term "transition planning," rather than "discharge planning" or "reentry planning" (American Association of Community Psychiatrists 2001). The AACP recommends "transition planning" as the preferred term because *transition* both implies bidirectional responsibilities and requires collaboration among providers. It is understood that some exoffenders will return to custody and as such reentry can be seen as part of a cycle of care. Transition planning is also discussed as a process and not an event. The APIC model—Assess, Plan, Identify, and Coordinate—describes elements of transition planning associated with successful integration back into community (Osher et al. 2002).

Specialized Community Supervision

At intercept 5, the opportunities to reduce the prevalence of persons with mental illnesses in jail and prison is very significant. The number of people with mental illnesses under correctional supervision has reached unprecedented levels and the vast majority is supervised in the community (Glaze and Bonczar 2007). With incredibly high caseloads and little access to community resources, probation and parole officers are often left with revocation to jail or prison as a punishment for failing to meet conditions of release. These "technical violations," where a new crime has not been committed, are the principle contributions to ballooning correctional populations. In this context, specialized community corrections caseloads have been developed to improve outcomes for persons with mental illnesses under community supervision. The key features of this programmatic response are smaller caseloads comprised exclusively of persons with mental illnesses, significant officer training on mental health issues, and extensive collaboration with community-based providers (Prins and Draper 2009). Studies support this model as effective in reducing recidivism rates among persons with mental illnesses under community corrections supervision (Roskes and Feldman 1999). However, with states facing the grim reality of enormous budget shortfalls, the resources to fund effective transition strategies like specialized community corrections supervision, effective mental health, and co-occurring substance abuse treatments are tough to identify.

Comprehensive, Effective Community-Based Care: The Ultimate Intercept

It has been said that any effort to keep people with mental illnesses out of the criminal justice system will only be as good as the community treatment and supports available—the ultimate intercept. Towards that end, this chapter now focuses on the linkage to community treatment. There are several EBPs that with adaptation have the potential to reduce jail days for persons with mental illnesses. In discussing justice-involved persons with mental illnesses, it is important to keep in mind the heterogeneity of this group. They differ in terms of the seriousness of their mental illnesses, charge levels, criminogenic risks, and access to community supports. Unfortunately, the criminal justice system rarely does an adequate job of screening, assessing, and individualizing responses to those identified as having a mental illness. And the mental health system rarely asks and details the nature of criminal justice involvement, or assesses for criminogenic risk. In fact, studies have found that almost one half of the clients seen for the first time at community mental health centers have had contact with the criminal justice system, and nearly one third of them had been sentenced to jail (Theriot and Segal 2005). Lumping justice-involved persons with mental illnesses into a single class does not allow for prioritization of scarce resources to those most in need. The need for valid and reliable screening and assessment

processes has never been greater. These processes will drive the development of effective integrated treatment and supervision plans. What follows are the services that should be available to reduce criminal justice involvement in persons with mental illnesses.

Integrated Mental Health and Substance Abuse Services

Since the majority of justice-involved persons with mental illnesses will have co-occurring addictive disorders, integrated treatments must be available. Effective interventions to reduce illicit and destabilizing substance abuse are critical. For nonjustice-involved persons with co-occurring disorders, integrated treatment has been identified as an evidence-based practice and its core components have been articulated (Center for Substance Abuse Treatment 2005; Drake et al. 2001). For justice-involved persons, the hypothesis underpinning effective co-occurring disorders interventions can be stated as:

> interventions (at the program or provider level) that reduce substance use (licit and illicit) and improve levels of functioning in persons with co-occurring disorders will reduce both the frequency of their involvement with the justice system and their time spent in justice settings or under correctional supervision.

Integrated treatment for justice-involved persons has been associated with reduced criminal activity (specifically the use of illegal drugs and violent behavior), fewer persons with co-occurring disorders at all points in the justice system, and improved reintegration of offenders with co-occurring disorders into community settings. Specific treatments within integrated programs include psychopharmacologic strategies (Noordsy and Green 2003), motivational interventions (Carey et al. 2002), and cognitive-behavioral interventions (Mueser et al. 2003). Several specific program models that use integrated treatments have been applied to justice-involved persons with co-occurring disorders. The Integrated Dual Disorder Treatment model is an EBP that combines program components and treatment elements to assure that persons with co-occurring disorders receive combined treatment for substance abuse and mental illness from the same team of providers (SAMHSA 2003) (see Chap. 23 for a detailed discussion). The evidence base for its effectiveness with justice-involved persons with serious mental illnesses is just beginning to accumulate (Mangrum et al. 2006; Osher 2007). The modified therapeutic community (MTC) is a residential treatment program for co-occurring disorders using integrated strategies that have been studied in justice-involved populations (DeLeon 1993). MTCs use the "community-as-method" as the basis for both its program and treatment integration. MTCs have been shown to significantly lower reincarceration rates and reduce harmful substance use for persons with co-occurring disorders, compared with groups receiving nonintegrated services (Sacks et al. 2008).

Supportive Housing

High rates of homelessness among justice-involved persons with mental illnesses have been previously discussed and must be considered in comprehensive treatment planning. Their housing needs range from owning their own homes or living in independent rental units to institutional care. Supportive housing can significantly decrease the chance of recidivism and is less costly on a daily basis than jail or prison. Supportive housing includes a variety of permanent housing settings coupled with on-site or easily accessible services. The service range includes case management, counseling, medical care, mental health and substance abuse treatment, vocational training, cognitive skills groups, and assistance in obtaining income supports and entitlements. Culhane et al. (2002) found that individuals with mental illness at risk for homelessness placed in supportive housing options in New York City had both reductions in shelter use and hospitalizations *and* spent fewer days in jail compared with the year before attaining housing. In addition, compared with a matched group of New York City residents without supportive

housing, they had fewer episodes of incarceration. Unfortunately, affordable housing is in short supply in many communities, and persons with criminal records often have trouble accessing public housing assistance. For greater detail, please refer to Chap. 33 concerning homelessness and Chap. 29 for a discussion of housing.

Trauma Interventions

Rates of physical and sexual abuse in jail and prison populations have been found to be at least twice as high as in the general population (Teplin et al. 1996). Among some criminal justice groups such as women with co-occurring mental and substance use disorders and histories of homelessness—histories of violent victimization are nearly universal. In response to this heightened recognition of the pervasiveness and profound consequences of trauma, many criminal justice systems programs have begun to incorporate an understanding of trauma and trauma recovery into all aspects of service delivery. This "trauma-informed" general strategy (see Chap. 12 for a detailed discussion) is often paired with trauma-specific interventions for persons meeting post-traumatic stress disorder (PTSD) criteria. Zlotnik et al. (2003) applied a well-established cognitive-behavioral model for the treatment of PTSD to a cohort of incarcerated women with PTSD and substance dependence and found positive outcomes consistent with its application in nonincarcerated women. While these studies suggest that trauma-specific interventions for justice-involved persons can positively affect trauma symptoms, no evidence exists that these interventions reduce rearrest and jail utilization.

Supported Employment

Assuming that some criminal activity is driven by the need for money, successful employment may mitigate subsequent contact with the criminal justice system. As detailed in Chap. 25, supported employment has emerged as an EBP over the past 15 years that can improve the success of persons with serious mental illnesses in competitive employment circumstances (Bond et al. 2008). There may need to be program modifications to accommodate to conditions of release which can require court or community correction monitoring concurrent with work hours. While there is limited data that suggest supported employment is as effective in improving work outcomes when the person with mental illness is justice-involved, there is no data on the impact of supported employment on criminal justice outcomes

Illness Management and Recovery

Illness management and recovery is actually a group of EBPs that teach persons with serious mental illnesses the required skills to manage their own illnesses in collaboration with health-care professionals and other natural supports (see Chap. 26 for details). The application of these EBPs has been demonstrated to prevent relapse and rehospitalization in addition to reducing the disabling effects of mental health symptoms (Mueser et al. 2002). There are several illness management and recovery program types (e.g., Wellness Recovery and Action Plan [WRAP] or social and independent living skills [SILS]) that share practice principles while employing different approaches. These programs have been implemented for persons with mental illnesses within correctional settings and appear to produce the expected social skill gains. There is no evidence concerning the impact of illness management and recovery on public safety outcomes. The common application of psychoeducational and cognitive components within illness management and recovery programs makes them well suited for adaptations that could address criminogenic thinking or anti-social tendencies.

Case Management and Forensic Assertive Community Treatment

Case management services are necessary for individuals with complex health and legal needs. Assertive community treatment (ACT) is a

well-documented EBP that combines treatment, rehabilitation, and support services within a multidisciplinary team (Dixon 2000). It is a high-intensity, high-cost service that is typically reserved for those most disabled by mental illness and persons who use multiple community acute and emergency services (see Chap. 24 for a detailed discussion). The ability of ACT to consistently reduce arrests and jail times among persons with serious mental illnesses has not been established (Morrissey et al. 2007). As a result, there has been a recent interest in augmenting ACT services by specifically focusing on justice-involved populations and training team members to be responsive to criminal justice partners (Weisman et al. 2004). These forensic ACT teams, or FACT teams, have been implemented in many communities around the country. Some demonstration studies have found significant reduction in jail days and arrests (Morrissey et al. 2007). The development of forensic intensive case management (FICM) teams is another effort to coordinate criminal justice supervision and treatment services. FICM focuses on the brokering of services rather than direct service provision. While brokered case management models are still a challenge for many communities with limited resources, they are sustainable in areas where services are more ample. The bottom line for many justice-involved persons with mental illnesses is that some form of case management is necessary and case management teams must have a sound understanding of legal issues. With their "criminal justice savvy" (Morrissey et al. 2007), case management teams can be expected to reduce recidivism and support client recovery in the community.

Cognitive-Behavioral Interventions

Critical to understanding how persons with mental illnesses end up in criminal justice settings are the concepts of "criminogenic risk and criminogenic needs." Criminogenic risks are factors associated with criminal conduct and arrest. Some of these individual characteristics are static factors that cannot be changed such as the early onset of criminal behavior (e.g., age of first arrest) or a family history of criminality (e.g., father is in prison). But some factors are dynamic such as criminal attitudes or values and cognitive emotional states (Andrews and Bonta 1994). Criminogenic needs are the dynamic factors most closely associated with criminal behavior and can be targeted for change strategies. Justice-involved persons with mental illnesses have been found to have more of these risks and needs than justice-involved persons without mental illnesses (Skeem et al. 2006). Most importantly, the dynamic factors can be mitigated with appropriate cognitive-behavioral treatment interventions. In addition, people who spend extended periods of time in custody are exposed to a different culture and experience stressful periods that include threats to their well-being and periods of isolation. In response to these circumstances, they may develop adaptive behavior that interferes with subsequent community adjustment (Rotter and Carr 2010). Cognitive-behavioral interventions targeted to criminogenic needs are promising practices with considerable face validity. With recognition of the high number of criminogenic needs in this population, interventions intended to change attitudes, values, and behaviors are likely to have an impact on recidivism. In fact, in general, the more criminogenic needs addressed by treatment and supports, the bigger the expected impact on return to jail and prison (Latessa and Lowenkamp 2005).

Accessible and Appropriate Medication

Treatment with psychopharmacologic medication can be critical to preventing an individual from entering the criminal justice system and for those who are incarcerated, continuing or initiating medication may be necessary. Having access to appropriate medication at appropriate doses, for sufficient lengths of time in jail or prison, and on release to the community is imperative. Research is inconclusive about specific medications and their impact on crime, but it is clear that effective psychopharmacologic strategies are a

prerequisite for full participation in other treatment, supervision, and supportive services. Like other persons with serious mental illnesses, access to prescribers, paying for medication, adherence, and continuity across systems are challenges for this population.

These programs and EBPs are components of a comprehensive strategy to reduce the overrepresentation of persons with mental illnesses in the justice system. Few communities have all components and none have sufficient capacity, yet inroads are being made. Financing these EBPs relies on a patchwork of block grant funding, public and private insurance, and uncompensated care. Advocacy for investments in these programs and services is essential. Passage of the Patient Protection and Affordable Care and Health Care and Education Reconciliation Acts in 2010 hold promise for increasing access to Medicaid-funded services for the vulnerable population of justice-involved persons with mental illnesses.

Conclusion

Community psychiatrists are working and will continue to work, with persons with criminal justice histories, and should develop expertise in the terminology of the criminal justice system. Recovery-oriented practices are as germane to justice-involved persons as those without criminal justice experience and must be integrated into treatment plans. Community psychiatrists must have a vision of what works, for whom, and under what circumstances. Gaining this expertise can be done formally by taking part in advanced training such as a forensic and/or community psychiatry fellowship programs. But effectively applying this knowledge requires active partnerships with criminal justice colleagues in law enforcement, courts, and corrections and justice-involved clients. If we are to avoid a return to a society where punishment inappropriately substitutes for care, a shared commitment to our communities' public health and public safety is of paramount importance.

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35 Disaster Victims and the Response to Trauma

Matthew N. Goldenberg, David Benedek, and Robert J. Ursano

Introduction

In late August of 2005, Hurricane Katrina roared ashore on the Gulf Coast of the southern United States, leaving in its wake large swaths of physical destruction and human tragedy. The storm resulted in the deaths of nearly 2,000 people, most of them residents of New Orleans, where the storm's water surge breached nearby levees and flooded nearly 80% of the city. Coastal communities in Mississippi and Alabama were also ravaged by the hurricane. During and immediately following the storm, many residents experienced extreme adversity—life threats, physical injury, lack of appropriate food, water, sanitation, or shelter. Some had to walk long distances through flood waters, while others were rescued from the rooftops of their homes by boat or helicopter. Many locals, including a disproportionate number of poor residents, were left homeless and unemployed, coping with the deaths of loved ones, the separation from family members, and the loss of important social institutions such as churches, medical clinics and hospitals, and community centers. The storm created a large diaspora, with thousands of Gulf Coast residents relocating to cities such as Houston and Chicago. Property damage due to the storm was estimated at over $80 billion, with the total economic cost estimated at up to $150 billion (Tate 2010).

Because of the destructive toll of Hurricane Katrina, much attention has been paid to the storm from a variety of perspectives. The psychological impact of the storm on the residents of New Orleans and other affected regions has been the focus of significant interest among mental health and public policy professionals. The American Psychiatric Association held its 2010 annual meeting in New Orleans in part to focus on important questions that Hurricane Katrina raised about the psychiatric dimensions of disaster (American Psychiatric Association 2010). What are the psychological and behavioral effects of disaster or other traumatic events? What is the trajectory of such effects? Who is at risk for significant problems? To what extent and by what means can the adverse sequelae of disaster be prevented or mitigated? How can mental health professionals, including psychiatrists, assist in disaster preparedness and response? This chapter will address these issues, especially highlighting the important roles that community psychiatrists and other mental health professionals can play in the pre-, peri-, and post-disaster setting.

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Defining the Problem

Disasters

While Hurricane Katrina was undoubtedly one of the greatest American tragedies of the last decade, it is hardly the only disaster that has or will befall the nation's communities or citizens. By definition, disasters are events that overwhelm personal and/or social coping resources (Ursano et al. 2007). Disasters are classically characterized in a variety of ways, differing in terms of type, intent of agent, and scale. Disasters can be natural (e.g., tornado) or manmade (e.g., terrorist attack), though the distinction blurs somewhat in instances like Katrina where a natural event (the hurricane) combined with human factors (inadequate levee construction) lead to such devastation. Disasters can result from intentional acts (e.g., bombing) or accidents (e.g., industrial spill). Disasters can affect a few individuals, a small community, an entire nation, or even large numbers of people in various countries simultaneously as in the Indian Ocean tsunami in 2004.

Worldwide in 2005, nearly 162 million people were directly affected by disasters, including natural events such as hurricanes, or earthquakes. Man-made disasters such as terrorism and war inflict a heavy burden in many parts of the world. In 2010, more than 30 armed conflicts raged in 26 countries (Project Ploughshares 2008). Millions of people have been forced to migrate as refugees as a result of conflicts. The United States military has been at war in Afghanistan and Iraq for much of the last decade. As of 2009, nearly 4,000 American service members had died; there had been about 20,000 evacuations for war injuries, with nearly 1,000 individuals having suffered amputations (Fischer 2009).

As was the case with Hurricane Katrina, disasters disproportionately affect the world's poor. Over 90% of deaths due to natural disasters occur in poor countries (McMahon 2007). Even in developed countries, poor citizens are most affected by disasters. An event of similar physical magnitude is likely to cause more deaths in a developing country than in a developed country. The disparity in disaster outcomes between rich and poor can be understood as a function of both pre-event vulnerability and post-event response. Factors such as geography, personal resources, community infrastructure, and political stability all impact the occurrence and consequences of natural disasters. Large disparities in the distribution of wealth and income may also lead to differential health outcomes.

The Mental Health Effects of Disasters

In the immediate aftermath of many disasters, affected communities often respond with an increased sense of cohesion and commitment to a common purpose. On an individual level, most people exposed to a disaster actually respond quite well—resilience in the face of adversity is the rule, not the exception. But many are not as fortunate. Some of those exposed to a disaster develop psychiatric disorders such as post-traumatic stress disorder (PTSD) or depression. Others experience reactions that, while not reaching a diagnostic threshold, are quite distressing, including feelings of grief, social withdrawal, sleep problems, or decreased concentration. Still others may change their health risk behaviors, including increasing their cigarette or alcohol use or altering their driving patterns (Hamaoka et al. 2007). Many disaster victims grow angry, resentful, or distrusting of those they deem responsible for either the disaster (e.g., industry in a chemical spill) or unhelpful in the response (e.g., government).

Distinguishing a "normal" reaction from a more problematic condition following a traumatic event continues to be a somewhat controversial issue. Transient psychological reactions such as fear, sadness, helplessness, grief, or anger in the aftermath of trauma are common and often referred to as acute stress reactions (ASRs). ASRs could be considered to be psychiatry's common cold—widely distributed, but minimally disabling and with expected full recovery, often without significant intervention. Although the DSM IV does not include ASR as a diagnosable mental disorder, the international classification system (ICD) does. Unfortunately, the posttraumatic reaction for a subset of the population seems more like a pneumonia or chronic bronchitis, with

a more severe, protracted course. It is this prolonged symptomatology and significant functional impairment that distinguish more pathological responses such as PTSD or Acute Stress Disorder (ASD) from less severe ASR.

Post-traumatic stress disorder is the psychiatric condition most often associated with disasters, and it is often the primary focus of the post-disaster mental health response. PTSD is rare among mental disorders in that an external event is etiologically necessary for the diagnosis. Post-traumatic stress disorder is characterized by the development, after exposure to a traumatic event, of symptoms of: (1) reexperiencing of the event, often through intrusive thoughts and/or nightmares; (2) avoidance of reminders of the event; and (3) hyperarousal, including startle responses and poor sleep. PTSD requires the presence of symptoms at least 1 month after the event and, like all mental disorders, impairment in psychosocial functioning. PTSD is presently classified as "acute" if the symptoms have been present less than 3 months, "chronic" if the symptoms last more than 3 months, and "delayed onset" if the symptoms arise at least 6 months after the event (American Psychiatric Association 2000). The data to support the distinction of acute and chronic is limited, and these modifiers are under consideration for revision in DSM V. As a minimum, many experts believe PTSD is chronic only after 6–12 months duration.

ASD has similar characteristics as PTSD but may only be diagnosed in the first month after a traumatic event. ASD is characterized by the same three symptom domains as PTSD, but is also characterized by the presence of dissociation—such as time distortion or feeling detached or outside oneself—at the time of the event (American Psychiatric Association 2000). Initially, the presence of ASD was thought to be the predictor of subsequent PTSD. Most current data support the finding that many people with ASD go on to develop PTSD, but not all. And many of those who do not meet the criteria for ASD are later diagnosed with PTSD. Peritraumatic dissociative symptoms, a core feature of ASD, are a risk factor for PTSD, but not the only one. Therefore, ASD is neither necessary nor sufficient for the diagnosis of PTSD (Bryant et al. 2008a). At present the best predictor of PTSD may well be high levels of PTSD symptoms in the first month. The DSM V is likely to include changes in the conceptualization of these disorders in order to better reflect this more recent evidence. Though ASD and PTSD are the most recognized disorders in the wake of the disaster, they may not even be the most common. Other psychiatric conditions may also occur either independently or comorbidly with PTSD. Major depressive disorder frequently develops following a traumatic event, and those with a history of depression may experience a relapse of their symptoms in the post-disaster setting. Anxiety disorders including panic disorder and certain phobias may also emerge or be exacerbated following a disaster. There have been multiple studies that indicate that substance use rises in the post-disaster setting, but it is not clear that the incidence of substance use disorders increases. While overall substance use may rise somewhat, research indicates that most of the increased substance use occurs in individuals with preexisting substance use disorders.

Depending on the nature of the disaster, some victims may present with psychological and behavioral symptoms as a direct result of physical injury or illness. Disaster victims with head injuries may suffer neuropsychological symptoms as a direct result of traumatic brain injuries. Those who sustain injuries or develop illnesses may present confused or agitated as a result of delirium. Some people who are dependent on medication or other substances (including alcohol or illicit drugs) may experience withdrawal symptoms if there is an interruption in their supply chain. Persons who experience more serious physical disabilities as a result of injury may experience psychological distress due to the loss of prior function.

Vulnerable Populations

Not all of those who experience a disaster are equally likely to develop psychological distress and/or psychiatric illness in its wake. Those with prior trauma exposure including adverse childhood experiences, those with pre-morbid psychiatric illness, females, children, the elderly, and

the physically disabled are at increased risk of PTSD after traumatic events, including disasters (Hamaoka et al. 2007). In addition to the direct victims of disasters, first responders such as paramedics, firefighters, police officers, soldiers, and other disaster workers are also at risk for the development of PTSD and other post-trauma psychiatric disorders (Benedek et al. 2007). Rates of post-traumatic psychiatric illness vary depending on the type of trauma. Multiple studies (most focused on non-disaster-related trauma) have suggested that interpersonal violence such as rape or assault results in higher rates of PTSD than noncrime trauma (Kelley et al. 2009; Breslau et al. 1998). Combat exposure is the trauma most associated with PTSD development in men (Kessler et al. 1995). Human-made disasters seem to be associated with higher rates of PTSD than natural disasters. It may be that the meaning of interpersonal trauma—that another person has intentionally harmed another—impacts the development of symptoms.

Persons with serious and persistent mental illness may be particularly vulnerable to disasters. Like much of the population, they often respond quite ably to assist themselves and others in a time of great need. But evidence suggests that they are less likely to have an emergency plan in place or appropriate access to supplies in the event of a disaster. They may be more reliant on others to assist them to evacuate or take other precautions prior to a disaster. Those with a history of mental illness may also be more likely to develop stress-related symptoms or a relapse of prior symptoms following a disaster. Those with prior diagnosis of PTSD may be particularly vulnerable to an exacerbation of symptoms due to an association of the current disaster and response (e.g., sirens) to their prior trauma (Center for the Study of Traumatic Stress 2011; Frieden 2006). Post-disaster disruptions in mental health care (including hospitals, physicians and pharmacies) and other social services (including financial assistance, supported housing and public transportation) may greatly affect the seriously mentally ill. Persons with chronic, severe mental health problems are often cared for by family members who may be injured or killed or have their attention otherwise diverted during and after a disaster. Because overall demand for mental health services often increases in the wake of a disaster due to the mass trauma exposure, diversion of resources away from care for the chronically mentally ill may result.

The Mental Health Interventions in the Disaster Setting

Prevention

ASD and PTSD are rare among psychiatric conditions in that a necessary etiologic element for the diagnosis is exposure to a specific traumatic event, including disaster. As a result, these disorders offer clinicians and policy-makers the specific opportunity to focus on prevention. Prior to or following a disaster, interventions may be designed to reduce the likelihood of a disorder (primary prevention). It may also be possible to identify persons with early symptoms in order to mitigate their suffering and prevent progression to a more chronic condition (secondary prevention). Among those who develop an illness such as PTSD, treatment of the disorder can reduce the negative impact of the illness and avert negative outcomes such as suicide (tertiary prevention). Tertiary prevention can be seen as synonymous with standard psychiatric treatment and rehabilitation.

Preventive interventions are often subdivided into three categories: (1) universal prevention, (2) selective prevention, and (3) indicated prevention. Universal interventions target the entire affected population. Psychological First Aid (PFA), discussed in more detail below, is a universal intervention that can be employed with all affected individuals following a traumatic event. Selective interventions focus on groups or individuals whose risk for developing PTSD or other long-term problems may be particularly high. Provision of additional support to all first responders is a selective intervention. Indicated interventions identify and treat persons who are already experiencing some distress in order to prevent a worsening of symptoms. Providing prolonged exposure therapy to people with ASD to prevent PTSD is an indicated intervention (Bryant et al. 2008b).

Before the Event

Given that, by definition, post-traumatic syndromes develop after a horrible event, prevention of the event itself could be an effective way to limit psychological distress. Cessation of war would reduce the amount of property damage, lower the number of displaced persons, limit the injuries and deaths of civilians and soldiers, and lessen the psychological sequelae of battle. Securing the levees in New Orleans or developing a more effective evacuation strategy may have reduced the scope of the disaster and prevented much physical and psychological suffering. While undoubtedly valuable in their own right, these interventions are largely beyond the scope of mental health professionals. But clinicians and especially public health practitioners can take some action in anticipation of a disaster in order to prevent post-event distress.

Planning at both the individual and community level in anticipation of a disaster is vital to an appropriate, organized response once an event occurs. For individuals and families, preparedness includes the creation of a disaster plan, including storage of at least 2 days of food and water, a flashlight, a portable radio and spare batteries, emergency phone numbers, and a meeting place for family members should evacuation be necessary. A large national survey suggested that nearly two thirds of respondents had not formulated a basic family emergency plan (National Center for Disaster Preparedness 2004). Public education campaigns can increase preparedness among families and potentially lower disaster-related distress. Because patients with severe and persistent mental illness are even less likely to appropriately plan for disaster, they may benefit from assistance in preparation from their mental health treatment team.

At the community level, pre-disaster preparedness involves ensuring that appropriately trained human resources (e.g., police, firefighters, military and healthcare providers), adequate physical resources (e.g., food supply, shelters), and a functioning communications system are available when needed. Role definition and coordination of activities among various government and other community agencies is very important, and can best be accomplished if organized in advance of a traumatic event. Gaining an understanding of why some people do not heed protective warnings, such as evacuation in the face of Hurricane Katrina, may help limit these maladaptive disaster behaviors and reduce traumatic exposure in the future. Pre-event identification of those who may be most vulnerable to disaster—for example, knowing the location of nursing homes, group homes, or hospitals—can help prioritize the response, and prevent later distress. Healthcare facilities, including psychiatric units or hospitals, should make appropriate preparations in the anticipation of disasters, including keeping emergency provisions on hand, and developing appropriate staffing and evacuation plans.

Another concept of pre-trauma prevention of PTSD or other post-traumatic psychological distress is the "inoculation" of people who may later be exposed. The related notions of enhancing resistance to psychological injury and building the capacity for resilience in the face of injury have led to a variety of policies and programs aimed at preventing adverse psychological sequelae. Current US military policies encourage training in simulated combat environments at least in part to reduce the likelihood of development of stress-related symptoms after genuine combat exposure. Such training decreases novelty of combat (and, therefore, the associated anxiety), increases self efficacy and social support skills, and directly decreases the risk of injury. A school-based, universal or selective intervention that teaches cognitive-behavioral and social problem-solving skills to children has been shown to lower rates of depressive symptoms, though results have been inconsistent (Gillham et al. 2008). In the last year, the US Army has begun a program known as Comprehensive Soldier Fitness, a set of universal interventions addressing physical (e.g., sleep, exercise, nutrition), emotional, and spiritual aspects of a service member's life, which seeks to enhance soldiers' psychological resilience in the face of war (Cornum 2009). It is not yet known whether this program will have a positive impact on soldiers' mental health including rates of PTSD or, by extension, whether even

broader-based initiatives in resistance- and resilience-building may be helpful in averting adverse outcomes following a disaster.

It is difficult to measure the value of preventive interventions, but the cost of inadequate preparation transcends the burden of the diseases such as PTSD or depression. Distress-related absenteeism and presenteeism (e.g., "at work but distracted by symptoms so not productive") and work missed to attend to the care needs of children affected also need to be factored into the cost. The financing of disaster preparedness and response is shared by federal, state, and local governments as well as private citizens and businesses. Emergency and disaster management agencies at the national and local levels are charged with the planning and execution of prevention and response efforts. Mental health professionals can become involved in larger-scale planning efforts through involvement with those agencies or through the Medical Response Corps, a volunteer division of the Office of the Surgeon General. Preparedness at the level of the physician office, clinic, or business is also important. Training is an essential element of budgets for most industries (including health care), so preparedness efforts should be factored into faculty/staff training and education budgets. Professional training of teachers, clergy, law enforcement, physicians, and other community leaders that includes concepts of PFA (see below) may prove to lower disease/distress burden and even be cost-effective.

During or Soon After the Event: Psychological First Aid and Primary Prevention

Since distress reactions—even in those without prior psychiatric illness—are common in the aftermath of trauma, emphasis should be placed not only on identifying and treating psychiatric illness, but on sustaining the mental health of the broader population. Vulnerable populations, including those physically injured in the event, first responders, and those with a history of mental illness, require planned intervention. A combination of universal and selective approaches may be the best approach, though specific evidence-based interventions are lacking and have proven difficult to research in traditional randomized controlled trials in the immediate aftermath of disaster. Using a combination of broad-based interventions for many and specific interventions for a few may optimize the care provided and efficiently utilize available resources.

PFA is a set of evidence-informed, guiding principles that are recommended as a first-line intervention for all individuals following traumatic events, prior to the development of any disorders (Hobfoll 2007). PFA principles include (1) safety, (2) calming, (3) connectedness to both instrumental and emotional support, (4) self-efficacy—both the belief one can do what is needed and has the skills to do so, and (5) optimism/hope. Mental health professionals familiar with these principles can advocate for their inclusion in any disaster response.

Establishing a sense of *safety* is paramount to the initiation of recovery. Until a person feels safe from an immediate threat—an earthquake aftershock, rising floodwaters, crime, spreading infection—fear may persist, and it is difficult to restore a sense of healthfulness. Transporting victims to higher ground, out of the crossfire, toward stable structures, or otherwise away from danger are important first steps. Providing appropriate security is another initial intervention that can yield benefits. Ensuring safety can go a long way in addressing the second component of PFA—*calming*. Anxiety and physiologic hyperarousal are normal and, often, adaptive responses to a stressful event. Acknowledging, normalizing, and validating these reactions is helpful for many, as is assisting in positively channeling increased energy. Community leaders are critical in promoting public calm in the face of a crisis by modeling a calm approach, delivering clear, accurate risk assessments, and providing explicit directions (Bushnell 2003). Mental health practitioners can assist other community leaders by emphasizing the importance of calm and clear information delivery. Clinicians, in caring directly for a recently traumatized patient, can be helpful in establishing a sense of safety and calm by providing appropriate direction and reassurance.

Another important element in a post-traumatic response is the promotion of *connectedness*. Social support is a relatively robust protective factor for psychiatric illness including PTSD (Butler et al. 2009; Pietrzak et al. 2009; Brewin et al. 2000). In the wake of a mass trauma, social and community structures may be compromised, especially if a population is geographically displaced or families are separated. Interventions that encourage reconnecting with friends, family, or others in one's social network can relieve both short-term distress and longer-term problems. Providing access to communication tools such as a telephone or email is helpful. Encouraging, as much as possible, geographic unification of families and/or friends is extremely beneficial.

One of the effects of a traumatic event is that people often feel they lack control—over the event itself as well as over their post-event life. Restoring *self-efficacy*—a sense of control and an ability to affect positive change—and instilling *hope* for the future are major goals of a successful response (Flatten et al. 2008). Only with hope do disaster and trauma victims begin to think of a future, perform work to care for themselves and others, and begin to rebuild a future. Encouraging a widespread return to work and school when possible is one good approach. Enlisting the population in key decisions and recovery projects is important to restoring a sense of self and collective efficacy while also strengthening social ties. For individuals, cognitive behavioral therapy may be able to assist in restoring that sense of control over one's life.

Operationalizing these five PFA principles is the challenge for disaster planners and clinicians who work with disaster and trauma victims. Ideal interventions in the post-trauma setting must be flexible and adaptable but also be able to be delivered on a broad scale by laypersons who may not have a background in mental health. More research is needed to establish evidence for specific programmatic elements, but there is increasing support for using these five principles in the development of population-based, post-trauma interventions.

Certain psychotherapeutic interventions should be used with caution or avoided in the acute setting. Once the standard of care following various traumatic exposures, universal, individual psychological debriefing (often referred to as critical incident stress debriefing, or CISD) has not proven to be helpful either in the relief of short-term psychological distress or in the prevention of PTSD (Rose et al. 2002). It is not clear why this is the case, but it may be that requiring people to discuss their recent traumatic experience in a prescribed fashion serves to activate rather than calm them. A more selective approach may more appropriately target those who could benefit from psychotherapy.

One Week to 1 Month After Traumatic Events: Acute Stress Disorder and Secondary Prevention

Those people whose adverse psychological responses are more severe or prolonged warrant special attention and monitoring. Most who are experiencing significant distress following a traumatic event visit a primary care provider—not a psychiatrist or psychologist—so screening for psychiatric disorders such as ASD may be more appropriate in that setting (Benedek and Wynn 2010). Recent studies have examined the use of short screening forms to identify PTSD in primary care (Gore et al. 2008). Regardless of diagnosis, most post-trauma care is accomplished in the primary care setting. This environment may also be less stigmatizing to many patients than the specialized mental healthcare clinic. Primary care providers often have longitudinal relationships with patients so they can provide additional support. Furthermore, in the wake of a trauma, many patient complaints are physical in nature, and primary care physicians are often skilled at determining how to evaluate and treat such symptoms (Engel et al. 2003). Supportive psychotherapeutic techniques including helping a patient to problem-solve can also be accomplished in the primary care setting. Primary care providers can also monitor their patients' clinical status, and can screen for psychiatric conditions including ASD, PTSD, and depression.

Pharmacologic intervention to reduce acute post-traumatic distress may seem intuitive, but

there is scant evidence that medication is particularly beneficial. There is little or no evidence that benzodiazepines are helpful in the prevention of or treatment of PTSD (Benedek and Wynn 2011). Though widely used and theoretically helpful—they are useful in the treatment of generalized anxiety disorder—benzodiazepines have shown little efficacy in treating the core symptoms of PTSD except for some hyperarousal symptoms. Risks also include rebound anxiety when stopping the medication and dependence. There is also some evidence that early treatment with a benzodiazepine may lead to increased incidence of PTSD at 1 and 6 months (Gelpin et al. 1996). There had been initial suggestions that beta-blockers used in the hours and days after the traumatic event might mitigate acute symptoms and prevent the development of PTSD. Despite some signs that beta-blockers reduced exposure-related physiologic arousal, a more recent placebo-controlled study failed to demonstrate superior efficacy of propranolol (Stein et al. 2007). Presently, there is interest in determining whether other classes of medication often administered in the trauma setting, such as opiates, might be helpful in preventing PTSD (Zatzick and Roy-Byrne 2006; Bryant et al. 2009).

Psychotherapeutic interventions that target patients with ASD have been shown to have some efficacy in the prevention of the development of PTSD. Data on ASD is somewhat limited, largely because enrollment in a research study during the acute post-traumatic phase (less than 1 month) can be difficult. Cognitive-behavioral therapy in patients with ASD has been effective in reducing rates of PTSD when compared with supportive therapy (Bryant et al. 1999). Prolonged exposure is thought to be an important component of that therapy.

Months After the Trauma: Treatment of PTSD and Tertiary Prevention

Much more is known about treatment once a diagnosis of PTSD has been made. Perhaps no intervention for the treatment of PTSD has as much evidence of its utility as exposure-based cognitive-behavioral therapies (EBCBT). There is no consensus on the appropriate categorization of the many varied psychotherapeutic interventions for PTSD. But the Institute of Medicine and the APA have both utilized EBCBTs as a broad, inclusive designation for therapeutic approaches and techniques that share, as the name suggests, common elements of exposure as well as cognitive reprocessing and/or behavioral modification (Benedek and Wynn 2011). Multiple clinical trials have demonstrated the efficacy of these psychotherapies.

Eye movement desensitization and reprocessing (EMDR) is a psychotherapeutic technique that combines elements of cognitive behavioral therapy, exposure therapy, and prescribed attention to eye movements of the patient. While there have been a number of studies that seem to suggest a benefit of EMDR, it is clear that the benefit is not due to the focus on eye movements. Instead, evidence suggests that the therapeutic benefit is related to the elements of exposure therapy and CBT—sharing the trauma experience and reprocessing its emotional content (Ursano et al. 2004).

The APA guidelines note the lack of formal, randomized controlled trial data to support the efficacy of psychodynamic psychotherapy. As with the study of psychodynamic therapy for other problems, data is limited due to challenges in study design. However, the conclusion reached by the APA leaves open the use of this psychotherapy for addressing the long-term personality elements of trauma exposure. Based on clinical consensus, the guidelines state that "a psychodynamic approach is useful in helping the patient integrate past traumatic experience(s) into a more adaptive or constructive schema of risk, safety, prevention, and protection, thereby reducing core symptoms of PTSD" (Benedek et al. 2009a).

Psychopharmacologic therapy is a mainstay in the clinical management of PTSD, and evidence supports a role for medication in treatment. There is substantial evidence that selective serotonin reuptake inhibitors (SSRIs) are efficacious in the treatment of PTSD, especially in women with the disorder who have been exposed to civilian trauma including physical or sexual assault and motor

vehicle accidents. There is less data to suggest that combat-related PTSD is as responsive to SSRI therapy, and their use is recommended with less confidence in treating that disorder (Benedek et al. 2009b). There is some evidence that SNRIs, particularly venlafaxine, is efficacious in the treatment of PTSD. Other classes of antidepressants that include bupropion, mirtazapine, and nefazodone have not demonstrated significant efficacy. Tricyclic antidepressants and monoamine oxidase inhibitors, though less widely studied than SSRIs, have also been demonstrated to be effective in the treatment of PTSD (Ursano et al. 2004). However, concern about safety often leads to physicians' reluctance to prescribe those classes of medication. Of interest, a small study of pediatric burn patients with ASD suggested that tricyclic antidepressants quickly, dramatically, and effectively reduced symptoms for most children compared to those who received chloral hydrate, though no follow-up was performed to determine longer-term outcome (Robert et al. 1999).

One of the most encouraging recent discoveries in the treatment of PTSD is that the alpha-adrenergic antagonist prazosin, in a number of placebo-controlled trials, reduced trauma-related nightmares and sleep disruption (Taylor et al. 2008; Raskind et al. 2007). There is some evidence that second-generation antipsychotic medications (SGAs) may lessen intrusive and hyperarousal symptoms, but more research is needed to establish whether or not SGAs are useful and safe in the treatment of PTSD (Benedek et al. 2009a). Caution about side effects including weight gain and metabolic syndrome is required.

Conclusion

It is unfortunate that disasters will surely continue to plague human beings around the globe. In the aftermath of such events, some people will experience adverse psychological reactions and behavioral changes. The majority of exposed individuals will exhibit resilience in the face of such trauma, while some will experience transient distress and still others will develop more debilitating disorders such as PTSD. There is hope that a preventive approach by policy-makers, disaster responders, and mental health practitioners may lead to a significant reduction of long-term psychiatric illness and disability. More research is needed to better understand the risk and protective factors associated with development of significant psychiatric illness following a disaster. Mental health practitioners can be helpful in delivering the effective treatments that are available for ASD, PTSD, and other post-disaster problems.

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36 Veterans and War

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Introduction

War has long been known to have harmful effects on the human psyche in addition to its obvious harmful effects on the body. Systematic study of the enduring effects of combat trauma in veterans began in earnest after the American involvement in the Vietnam War, along with serious attention to finding effective treatments. To a great extent, Vietnam veterans themselves led the fight for recognition and treatment of what we now know as posttraumatic stress disorder (PTSD). If there is a positive legacy from this controversial and divisive war, this may be it. The development of treatment for PTSD in the Veterans Affairs health system and in the military may also serve as a good example of the "consumer empowerment" often spoken of in the community mental health movement, in that those suffering from the disorder have been instrumental in setting up systems for its care. While we dedicate this chapter to all veterans, past, present, and future, we especially honor the Vietnam veterans who have striven to ensure that no soldiers will return from war to a nation unprepared to welcome them and to treat their psychological wounds when necessary.

Mental health care for American veterans has been moving from massive inpatient facilities to the community for years. While any veteran who has been discharged from the military under honorable conditions is eligible for care in Department of Veterans Affairs (VA) facilities, the focus and priority since Abraham Lincoln established VA's predecessor has been "to care for him that has borne the battle." Of late, VA has worked to adopt and even lead innovations in community mental health by providing easy access to the most up-to-date treatments, integrating mental health with primary care, encouraging care that is patient- and family-centered, and working for the adoption of the recovery model (Veterans Health Administration 2008). In recent years, in order to address the problem of veterans and soldiers not seeking or remaining in mental health treatment (Harpaz-Rotem and Rosenheck 2011), VA has taken the initiative to overcome negative perceptions of quality that date back at least to the return of the Vietnam War veterans from combat (Blank 1985), as well as to prepare for the high numbers of veterans returning from current wars in Iraq and Afghanistan with mental disorders such as PTSD and depression (Hoge et al. 2004). In this chapter, we will review mental health care for veterans in more detail, with an emphasis on those who have served in combat capacities.

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History and Evolution of Approaches to the Mental Health Care of Veterans

The VA reports that of all the world's nations, the US has developed the most comprehensive system of assistance for military veterans. The federal government began granting pensions to veterans during the eighteenth century and established the first medical center for veterans in the early nineteenth century. When the US entered World War I in 1917, Congress established a new system of benefits for veterans. By 1930, the VA health care system contained 54 veterans' hospitals. Presently, the VA system consists of 171 major medical centers, more than 350 outpatient care clinics, 126 nursing homes, and 35 domicillaries. A broad spectrum of care is available to veterans through the VA system, including medical, surgical, rehabilitative, and mental health care (United States Department of Veterans Affairs 2011).

Mental health care for American veterans has seen considerable progress over the centuries. While mental health concerns were largely dismissed or misdiagnosed in the eighteenth century, an interest in soldiers' mental health began to develop during World War I. At that time, mental health intervention was largely intuitive and focused on rest, sedation, emotional validation, identification with other soldiers, and the securing of benefits. Following the United States involvement in the Vietnam War, veterans' mental health, specifically PTSD and comorbid disorders, became a research topic of considerable interest to the psychiatric community (Pols and Oak 2007). Today, numerous psychotherapeutic and psychopharmacological interventions for the mental health conditions most often affecting veterans are available at VA medical centers and in the civilian community.

Population Demographics

Mental health care at VA facilities covers the full range, from 20-year-olds just returned from Iraq or Afghanistan to World War II-era veterans in their late 80s and 90s. Though men are still the majority of patients seen, as the percentage of women serving in the military increases, so does the percentage of female VA patients (currently 8.1%) (National Center for Veterans Analysis and Statistics). The racial and ethnic backgrounds of VA patients reflect the diversity of the nation as a whole. At this writing, Vietnam War veterans are the largest single group, as those who have served in Operation Enduring Freedom and Operation Iraqi Freedom are only beginning to present for treatment in large numbers. Approximately 22.7 million Americans are military veterans, and approximately 8.3 million receive care in the VA system.

Present-Day Mental Health Care for Veterans

Assessment and Screening

Within the military and VA health care systems, screening and assessment of active and potential mental health and medical issues is a standard practice. Of note are the pre- and postdeployment mental health screenings designed to promote appropriate intervention and inform decisions about deployment status for psychiatric issues by the military (Chard et al. 2008).

General Mental Health Treatment

Medication

As mentioned, any mental illness suffered by any eligible veteran presenting to the VA is treated. The practice of psychopharmacology at VA clinics differs in some ways from that commonly seen in community mental health centers. First, VA uses a restricted formulary designed to control cost and promote the use of medications with the greatest base of evidence for effectiveness. Expensive, newer (especially "me too") drugs are nonformulary (available only with a pharmacy consultation detailing reasons for use) or not available unless they have proven advantages over formulary medication for the same indication. However, medications that may be costly to patients in other sectors, such as atypical antipsychotics, are

available to veterans for the same copay as any other medication, or without charge if the condition is officially rated service-connected or if the veteran's income is low enough. Second, the use of the VA-wide computerized medical record and ordering system (CPRS) allows physicians and prescribing nurse practitioners to be immediately warned if they order a medication that has previously been associated with an adverse reaction in that particular patient at any VA facility. Significant drug–drug interactions are also flagged in real time. The prescriber can also see all medications currently prescribed for the patient at all VA facilities, obtain a history of past medications, and view when and if refills were ordered by the patient.

Performance measures are issued to evaluate adherence to standards of care at VA centers. These are usually based on the required completion of specific clinical reminders at visits. For example, patients prescribed atypical antipsychotics are required to have an annual discussion of metabolic risks associated with these medications, and to have serum glucose, lipid levels, and hemoglobin A1C measured annually. All patients on any antipsychotic must have an AIMS exam quarterly. Such information is tracked and used to evaluate facilities. Other data are collected in aggregate and made available to clinicians and facilities to evaluate trends in practice compared to other sites (Veterans Health Administration 2008). An example of this is the collection of data regarding percentage of patients on antipsychotics who are on more than one atypical agent, with the assumption that the lower this percentage, the better the practice.

Psychotherapy

Many VA medical centers, VA community-based outpatient clinics, and military installations have a variety of individual, group, couple, and family therapies available from credentialed providers. Traditional treatment and a growing number of evidence-based treatments are available in these various modalities. A number of military installations also have mental health services available for nonmilitary spouses and children. In addition, referrals to community providers are available through the military insurance programs for families of active duty military personnel. Within the VA, spouses and children may be seen in connection with the veteran's care. Family involvement in the veteran's care is strongly encouraged by the VA.

Peer-to-Peer/Veteran Communities

Several forms of peer-to-peer veterans' groups and communities are available, including veterans' service organizations, clubs, peer-led self-help groups, and supportive groups overseen by volunteers or clinicians employed by VA. The benefit exists in the recreation of a cohesive group, which may mirror the groups or units veterans remember from their enlistments. The groups can provide support, while veterans work toward recovery. Of the various groups available to veterans, the Vet-to-Vet program boasts the highest rating of group member satisfaction.

Vet-to-Vet is a peer-led education and support group developed by decorated Vietnam combat veteran (and schizophrenic), Moe Armstrong. Vet-to-Vet offers an independent design for mental health services while also incorporating professional oversight and partnership. This partnership increases the long-term viability and sustainability of the groups (Armstrong et al. 2008).

Posttraumatic Stress Disorder

PTSD is a specific anxiety disorder which may develop in individuals exposed to events in which they feel acute horror, fear for their physical or sexual integrity, or fear for their lives or the lives of others. PTSD is characterized by three types of symptoms: (1) reexperiencing the trauma (e.g., though nightmares or intrusive memories), (2) avoiding stimuli associated with the trauma (e.g., people or places which remind the individual of the trauma), and (3) increased arousal (e.g., paranoia and hypervigilance). If symptoms persist for longer than 30 days, PTSD (as opposed to acute stress disorder) may be diagnosed. PTSD is a topic of considerable concern among veterans and the clinicians who assist them. As such, we have designated an entire subsection of our chapter solely to PTSD.

The prevalence of PTSD among veterans is considerably higher than among community samples of adult Americans, which is estimated at around 6.8% (Kessler et al. 2005). The prevalence of PTSD among male veterans who served in Vietnam is estimated to be 30.9%, and the estimated prevalence among female Vietnam veterans is 26.9% (Kulka et al. 1990). The prevalence among Gulf War era veterans is estimated at 10.1% (Kang et al. 2003), and the prevalence among Operation Enduring Freedom/Operation Iraqi Freedom veterans is tentatively estimated at 13.8% (Tanielian and Jaycox 2008). The relatively high prevalence of PTSD among veterans is not surprising given the acutely stressful circumstances that tend to characterize war zones. Aside from trauma related to direct combat, veterans also face the threat of military sexual trauma and the horrors wrought by war (e.g., witnessing torture, handling the dead, and seeing wounded and orphaned civilians).

Encouragingly, a number of psychotherapeutic interventions are supported in the current literature to treat PTSD. Psychotherapy, often combined with psychopharmacological intervention, often provides considerable relief for veterans experiencing PTSD symptoms. In an effort to provide the most efficacious treatment for PTSD, VA has implemented a national mandate which supports the use of two psychological treatments proven effective in the treatment of PTSD in randomized controlled trials (Cognitive Processing Therapy and Prolonged Exposure Therapy). A large-scale initiative was instituted to ensure dissemination of evidence-based psychotherapeutic treatments for PTSD throughout the Veteran's Health Administration (Karlin et al. 2010).

Individual Psychotherapeutic Intervention

Cognitive Processing Therapy

CPT is an evidence-based treatment for PTSD. CPT focuses on the patient's beliefs regarding the traumatic event. In particular, CPT targets the patient's attempt to reconcile information from the trauma with prior cognitive schemas through assimilation (altering incoming information to match prior beliefs), accommodation (altering beliefs enough to accommodate new information), and/or overaccommodation (altering beliefs about the self and the world to the extreme). Therapists practicing CPT help their patients work toward accommodation (i.e., balanced beliefs such as "although I made one mistake, I am not a bad person"). CPT consists of approximately 12 50-min sessions, held once or twice per week. The treatment consists of the following phases: (1) education on PTSD, thoughts, and emotions, (2) processing the trauma, (3) learning to challenge maladaptive beliefs, (4) trauma themes (safety, trust, power/control, esteem, intimacy), and (5) facing the future. The full CPT protocol includes detailed written trauma accounts; however, an alternate version, called CPT-C, focuses on cognitive restructuring only without the trauma accounts (Resick et al. 2010). A recent dismantling study (Resick et al. 2008) found both the full CPT protocol and CPT-C to be efficacious in alleviating symptoms. Both protocols produced better outcomes than written trauma accounts alone. CPT and CPT-C may also be used in group therapy, and the VA has disseminated a group therapy manual for CPT with a veteran/military population (Chard et al. 2008).

Prolonged Exposure Therapy

PE materialized from the Emotional Processing Theory of PTSD. This theory states that amelioration of PTSD symptoms occurs when trauma survivors emotionally process their traumatic experience. This is accomplished by activating the fear structure through repeated exposure to the trauma memory and incorporation of corrective information which disconfirms trauma-related cognitive distortions (National Recovery Month 2011).

The aim of exposure therapy is to reduce unrealistic anxiety through confronting anxiety-provoking or avoided thoughts, situations, activities, and people which are not inherently harmful (Cahill et al. 2006). In vivo exposure begins after the therapist and patient together construct a hierarchy of situations that the patient has been avoiding. The patient will then systematically progress

through the hierarchy in order to see that anxiety will diminish over time without the use of avoidance (Foa et al. 2007).

Group Psychotherapy

Group psychotherapy is used throughout the VA system to teach veterans effective coping skills and improve their psychosocial functioning. Time-limited, skills-focused groups targeting a number of common symptoms of PTSD have emerged. Although there are many types of therapy groups offered to veterans, this section will focus on group protocols which have been developed by VA researchers and widely disseminated throughout the VA system. VA Mental Illness Research, Education, and Clinical Centers (MIRECC) researchers have developed several resources for provision of group therapy for veterans which are available at mirecc.va.gov. Multiple group therapy protocols have been developed (Anger Management Series, Mental Illness Research, Education, and Clinical Center 2011a; Relaxation Enhancement group protocol, Mental Illness Research, Education, and Clinical Center 2011b; group therapy protocol for improving sleep, Mental Illness Research, Education, and Clinical Center 2011c; Perlis and Lichstein 2003, and the Courage manual, a protocol for veterans who have experienced sexual trauma, Mental Illness Research, Education, and Clinical Center 2011d).

Medication

Although few medications for PTSD have been evaluated systematically, and even fewer have FDA approval (VA/Department of Defense Clinical Practice Guidelines for Management of Post Traumatic Stress), most veterans being treated for PTSD receive prescriptions. Selective serotonin reuptake inhibitors (SSRIs) are generally the first-line agents (Jeffreys 2010), since two, paroxetine and sertraline, are the only FDA-approved medications for PTSD (though based on studies in nonveteran populations), and two more, citalopram and fluoxetine, are very widely prescribed. SSRIs, however, are by no means universally effective and may not always be tolerable. Sexual side effects limit use in many veterans. In the search for better treatment, most medications used for depression and anxiety have been examined (Friedman and Davidson 2007). The SNRI venlafaxine has been used, and bupropion, though it has no clear serotonin reuptake blocking activity and is not useful for other anxiety disorders, appears effective in some veterans with PTSD, possibly due to its effect on the often comorbid depressive disorders. Recently, more attention has been paid to the novel agent mirtazepine, not only for its antidepressant and sedative effects, but for possible direct effects on PTSD symptoms (Schoenfeld et al. 2004). Despite the classification of PTSD as an anxiety disorder, benzodiazepines for daytime use have not been found effective in clinical trials (VA/Department of Defense Clinical Practice Guidelines for Management of Post Traumatic Stress), and well-known negative aspects of their use (dependence, disinhibition, suicidality) have led to their listing as "not recommended" in VA treatment guidelines.

Psychopharmacology may be at an inherent disadvantage in combat-related PTSD because the condition is not solely an anxiety disorder, but is so often mixed with depression, guilt (both of the survivor variety and that associated with killing the enemy, Grossman 2009), and bereavement. While the search for more effective medication continues, encouraging multimodal approaches involving medication, psychotherapy, social support, spirituality, and work/recreation/activity is the current standard.

Special Topics

Mental Health Intensive Case Management

VA established MHICM in 1987 (Neale et al. 2007). MHICM is derived from Assertive Community Treatment, the most well-known approach to providing intensive case management (Stein and Test 1980). Patients targeted for

MHICM inclusion have a diagnosis of severe and persistent mental illness (e.g., schizophrenia, bipolar disorder, major affective disorder, severe PTSD), severe functional impairment, are inadequately served by conventional clinic-based outpatient treatment, utilize psychiatric hospitalization at a high rate, and are clinically appropriate for intensive outpatient treatment rather than inpatient treatment. The program is characterized by frequent patient contacts (typically 2–3 per week, primarily through home and community visits), low caseloads for clinical employees, and a transition to lower intensity care after 1 year of MHICM treatment if appropriate (Department of Veterans Affairs 2006). Recent data reveal that MHICM operates at over 100 VA facilities and serves over 6,000 veterans per year. The program appears to reduce symptom severity, reduce hospital use, and improve quality of life and patient satisfaction (Neale et al. 2007). It is considered a cost-effective approach to care for individuals with severe mental illness (Rosenheck and Neale 1998).

Substance Abuse Treatment

Substance use disorders are defined as the dependence on or abuse of alcohol and/or illicit drugs, which includes the nonmedical use of prescription drugs. Veterans have demonstrated a higher risk of developing substance use disorders than the general population, and research suggests that the prevalence of substance use disorders among veterans may be rising. In 2002, veterans with substance use disorders accounted for approximately 12% of patients being treated by VA (National Recovery Month 2011).

Certain factors have been identified which may increase the risk of the development of substance use disorders among the veteran population. These risk factors include stress related to the physical and mental challenges of their military service, exposure to combat-related trauma, and the presence of co-occurring disorders such as PTSD and depression (National Recovery Month 2011).

Individual Treatment Protocols: Cognitive Behavioral Therapy, Acceptance, and Commitment Therapy

In addition to treatments specified for PTSD, evidence-based psychotherapeutic intervention is available for other mental health disorders which commonly occur among veterans. Of particular focus for the VA at this time are cognitive behavioral therapy (CBT) and acceptance and commitment therapy (ACT).

CBT is a popular manualized treatment with a robust literature base. CBT is intended to address symptoms of depression and is generally implemented in a structured, time-limited fashion. Therapy is executed in a systematic manner, with patients keeping written records of thoughts, feelings, scheduled pleasant activities, and solution-focused strategies. Therapists implementing CBT encourage patients to acknowledge the connections between events, faulty thoughts and perceptions, and negative emotions. By empowering patients to choose functional thoughts and behaviors, therapists help patients to exercise better control of their emotions and make choices which yield satisfying consequences (Brown and Karlin 2010; Beck 1967).

ACT is a newer intervention with a growing empirical base. Therapists implementing ACT seek to improve patients' practice of mindfulness (Walser and Westrup 2007) as they experience unpleasant memories and emotions while remaining committed to adaptive behavioral change (Hayes et al. 1999; Linehan 1993). This intervention may be used as adjuctive treatment for evidence-based treatments for PTSD (e.g., CPT and PE). It can also be effective in treating depression and Axis II disorders.

Suicide/Suicide Prevention

In January 2010, VA released new data which indicated that the rate of suicide among military veterans had increased by 26% between 2005 and 2007. On average, 18 veterans commit suicide each day. This growing awareness of the high

risk of suicide in veterans has led to increased efforts by VA to identify risk factors among the veteran population and to implement effective suicide prevention interventions (Bruce 2010).

Suicide rates among veterans are the highest in the oldest age groups. However, in contrast to the civilian population, suicide rates are particularly high for veterans of the wars in Iraq and Afghanistan. Several risk factors have been identified which may contribute to the increased risk of suicide among the veteran population including the following: (1) prolonged combat, (2) physical injuries, including traumatic brain injury, (3) psychiatric conditions such depression and PTSD, (4) availability and knowledge of firearms, and (5) lack of a sense of purpose and control in one's life following military service (Bruce 2010).

Through structural changes and the implementation of new programs, VA has sought to combat this growing epidemic. Such changes include the addition of Suicide Prevention Coordinators at VA facilities and the funding of research focused in suicide intervention development and identification of suicide risk factors (Bruce 2010).

Homelessness

In a 2009 report published by Housing and Urban Development, researchers estimated that on any given night, approximately 76,000 veterans are homeless. During the year of their study, researchers found that approximately 136,000 (or 1 in 168) veterans were housed for at least one night in a homeless shelter. These numbers indicate that roughly one third of the US homeless population is comprised of veterans. As is the case in the general homeless population, many of these veterans struggle with mental illness, drug and alcohol addiction, or both (US Department of Housing and Urban Development, Office of Community Planning and Development 2011). Therefore, it is imperative that in order to address homelessness, the more pervasive problems of substance abuse and mental illness must first be identified, addressed, and successfully treated.

The Healthcare for Homeless Veterans (HCVC) program was implemented to spearhead the VA's goal to eradicate homelessness in the veteran population by the specified target date of 2015. Homeless veterans often require a broad range of services and support in order to help maintain day-to-day living. HCVC utilizes mental health services, housing resources, education and job-skills training, supportive employment, and rehabilitation services in conjunction with existing federal, state, and community outreach organizations to achieve that goal (Department of Veterans Affairs, Office of Research and Development 2010).

Women Veterans

The number of female military recruits has grown in recent years. In 1998, 20% of new military recruits were women; currently, that number is projected to be as high as 30% (Dobie et al. 2004). Subsequently, the number of women treated by VA is projected to increase substantially in coming years. In 2008, 281,000 female veterans were treated in VA, and this figure is predicted to increase by 17% (330,000) by 2033 (Freedy et al. 2010).

Treatment of women veterans has become a point of considerable focus in recent years as VA takes steps to ensure parity and comprehensiveness in care for males and females. Researchers have also given this topic attention as they have examined the differing effects of trauma on men and women and the different diagnoses assigned to men and women upon return from deployment.

In May 2010, VA released new initiatives pertaining specifically to the care of women veterans. The purpose of these initiatives was to ensure that women veteran's healthcare needs, including mental healthcare needs, are met thoroughly and that female veterans are afforded the same access to comprehensive services as are male veterans (Veterans Health Administration 2010).

Military Sexual Trauma

The DoD, and each branch of the US Armed Services, have issued directives to address the issue of MST. The Sexual Assault Prevention and Response Program (SAPR) is the comprehensive DoD policy on the prevention and response to sexual assaults. In this program, a reporting system and response options are detailed for those in active military duty. A Sexual Assault Response Coordinator (SARC) serves as geographic or installation point of contact to oversee sexual assault prevention and awareness training and to ensure the provision of medical and mental health evaluation and treatment to victims of sexual assault. The SARC also lets the victim know of his or her options regarding reporting or not reporting the assault to command and pressing charges (DoD Directive Number 6495.01).

The medical and psychological impact of MST is variable. MST appears to be associated with increased risk of a number of mental health disorders (Kimerling et al. 2007). Anxiety disorders, including PTSD, mood disorders, self-injurious behaviors (including suicide attempts), and substance abuse disorders are among the most commonly seen psychiatric issues of MST survivors.

Supports

Recovery/Local Recovery Coordinator

A recovery-oriented approach to coordination of care and mental health treatment as an initiative was established and adopted by the VA on September 11, 2008. The core components of recovery include an emphasis on self-directed responsible care with individualized person-centered care plans. These unique care plans are developed through a strengths-based system which fosters a clinical partnership with the provider and encourages hope, respect, and empowerment to achieve holistic, peer-supported treatment. The goal of the recovery-oriented treatment paradigm is that persons with mental illnesses are afforded the opportunity, and given support on multiple levels, to optimize their engagement in the community and lifestyle of their choosing (Davidson et al. 2006).

Military Families

According to the DoD, more than half of the active duty military forces, National Guard, and Selected Reserve have "family responsibilities," defined as having a spouse and one or more dependents. Of married active duty military personnel, 12.7% are in dual military marriages (i.e., marriages in which both partners are employed by the military). Of Selected Reserve personnel, 5% are in dual military marriages. Almost two million children in the US are growing up in military families. The lives of these military families are impacted by factors such as rank of the service member, military occupational specialty, deployment status, frequency of relocation, availability of family and peer support, and access to services. The DoD and each branch of the military have developed services and policies to support military families (Department of Defense 2006; Karney and Crown 2007). Unlike families of active duty military personnel, the families of National Guard and Reserve units may be more isolated and have less immediate access to support and services since the families of these service members do not always reside clustered around military installations (Castenada et al. 2008). During the deployment of a parent, children are more likely to present with mental health and behavioral disorders (Eide et al. 2010). Older children, aged 11–17, report more school-, family-, and peer-related issues associated with deployment (Chandra et al. 2010).

The needs of spouses and children are often addressed through services and clinics available at larger bases and military medical centers. Family support personnel and consultants can often provide needed assessment and treatment or make referrals for such services. Databases and referral sources such as military chaplains and healthcare professionals can help to connect distressed families with available resources. Family members of veterans can be seen in

conjunction with the veteran's treatment at many VA clinics, Vet Centers, and medical centers where family and couples therapy is available (Veterans Health Administration 2008).

Chaplain Services

Spirituality is a key component of any treatment plan. Patients and practitioners alike need to understand the importance of spirituality and the distinction between spirituality and religion. Healthy spirituality is the essence of peace, balance, and wholeness within each person. Religion is a part of the spiritual practice of many individuals. However, it should never be confused with spirituality. Many people who are very religious may be suffering spiritually. The best resources for addressing these issues are qualified pastoral or spiritual counselors. The Department of Veterans Affairs Chaplain Service is available for referral or consultation for veteran patients and may be contacted through any VA Medical Center (University of West Florida 2011; Sandage and Jankowski 2010).

Conclusion

This chapter reflects how the VA has developed community mental health evidence-based therapeutic approaches and a plethora of specialized services to meet the challenges faced by this special population.

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37 Clinical Issues and Programming for Lesbian, Gay, Bisexual, and Transgender Populations

Ronald E. Hellman

Introduction

Beginning in the mid-twentieth century, sexual minorities in the United States emerged from a past defined and pathologized by the mainstream in a revolution of self-definition and affirmation. In the same era, the realities of community work in psychiatry lead to reconceptualizations that encompassed the broader needs of people with mental disorders. These dual transformations, which continue today, sparked a paradigm shift in the landscape of social exchange between psychiatry and lesbian, gay, bisexual and transgender (LGBT) individuals, from one that was hierarchical to one that is now collaborative.

Today, the ability to provide a culturally relevant context and content to LGBT individuals with mental illness may be the most significant determinant in the promotion of early and sustained connections to needed treatment (Hellman 1996). A therapeutic environment that resonates so personally has the ability to heal by recasting alienated sexual minority patients as LGBT persons in recovery from mental illness. As heightened understanding, acceptance, and integration lessens distrust of the mainstream by LGBT individuals, greater demand for psychiatric services by sexual minorities in public mental health settings should be anticipated by community psychiatrists.

LGBT Cultural Identity and Mental Illness

How can community psychiatrists, their service delivery systems, and professional organizations meet this new challenge? As a start, every community clinician and administrator should be able to answer the following question: *Why should it matter to me if the patient is LGBT when I am treating an illness such as schizophrenia?*

The answer illustrates why it is essential to look beyond symptoms. LGBT patients with psychiatric disorders present to clinicians at different stages of LGBT psychological development and phases of the life cycle. If a person is just coming to terms with his or her sexual identity, mental illness can interfere with and constrain its maturation. If they are exploring, or have established themselves in the LGBT world, it can pull them away. If they have a past history of psychiatric treatment, the extent to which their sexual identity had been affirmed, ignored, or devalued will influence their expectations in current and future psychiatric settings.

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As patients, LGBT individuals with major mental illnesses are just as likely to be shunned in the LGBT community as in mainstream society. Many are not able to reintegrate within an LGBT community-at-large, placing greater responsibility on the mental health community to address the cultural need (Hellman and Klein 2004; Hellman 2011; Hellman et al. 2010).

Coming out, the process of disclosing one's sexual identity, now extends to ongoing interactions in the mental health setting. Social interaction on inpatient units, in day programs and outpatient settings, in group therapy, residences, and with secretaries, nurses, other personnel, and families on which they depend constantly expose the LGBT person to the possibility of homophobia (Herek 2000), transphobia (Shipherd et al. 2010), heterosexism (Simoni and Walters 2001), or accusations of not being open and truthful if they do not disclose (Ritter and Terndrup 2002). The ability of the LGBT community to buffer such experience is curtailed when the LGBT person experiences mental illness, because it is typically not equipped to engage those who are, for example, hallucinating, delusional, thought disordered, manic, or severely depressed. And, fear of being stereotyped, misunderstood, or inadequately assessed and treated can contribute to a reluctance to engage with healthcare services (Corrigan et al. 2003).

LGBT patients tend to be more suspect of mainstream treatment environments, because they are predominately heterosexual and cisgendered (Lenning 2009). The dual alienation associated with major mental illness and sexual minority status can contribute to a lack of well-being and subsequent reinforcement of the "patient" role. Unless there is evidence for inclusiveness through affirmation in the psychiatric setting, getting better from mental illness can mean investing significant effort in adapting to mainstream culture, or remaining invisible regarding sexual and gender orientation. Strained treatment alliances subject these patients to greater risk for nonadherence and poorer psychiatric outcomes (Jamison 2006; U.S. Department of Health and Human Services 2001). However, with relevant cultural programming, LGBT patients with years of prior treatment for major mental illness can show remarkable gains (Hellman et al. 2008, 2010).

The "LGBT" Rubric and Issues for Epidemiology

"LGBT" has become a widely accepted designation for minorities based on sexual and gender orientation. All members of these subgroups are subject to similar prejudices rooted in beliefs and traditions about sexuality and gender. Bias towards one subgroup tends to generalize to all four, and the subgroups often come together for social and political strength (Ferris 2006). Some advocate extending the term to include those who are questioning their sexual identity, and those who are intersexed ("LGBTQI").

The subgroups refer to forms of naming that imply a cultural identification. For example, a "transgender male" is most likely to have a cultural identification with the transgender community. A similar person, who identifies simply as "male," may predominantly identify with the general male population. A male identified as "gay" tends to have a cultural identification with the gay community, while a male who engages in same-sexual behavior may be identified as a "heterosexual" or "straight male" if his primary cultural identification is with the heterosexual community.

Psychological gender incongruence with anatomical sex distinguishes the transgender subgroup, while gender distinguishes the lesbian and gay male subgroups by virtue of their anatomical differences, gender of attraction, social roles, and distinct histories. The bisexual and transgender groups are inclusive of both genders. Members of each subgroup may not identify or mingle with the others, but there is wide variation in the social mix. The subgroups often relate in supportive and respectful ways, but sometimes stigmatize each other. When one group predominates, it can alienate the others.

Psychiatry categorized the homosexual group as pathological prior to 1973, continues to categorize the gender dysphoric group, but never designated bisexuality as a diagnosis.

LGBT Prevalence

With these issues in mind, research has estimated a prevalence of adults with primarily homosexual experience as between 1.3 and 10% for males and 1–6% for females (Fay et al. 1989; Hunt 1974; Kinsey et al. 1948, 1953; Pietropinto and Simenauer 1977; Sell et al. 1995). Lauman et al. (1994) found that 7.7% of adult males report same-sexual desire, 4.9% homosexual behavior, and 2.8% a homosexual identity. For adult women, 7.5% report same-sexual desire or behavior and 1.4% a homosexual or bisexual identity. Sell et al. (1995) found that 8.7% of males and 11.1% of females in the United States report same-sexual attraction, but no homosexual behavior since age 15.

Bisexual behavior has been found to range from 5.8 to 8.6% in adult males, and 3.8% in females (Laumann et al. 1994; Sandfort et al. 2001), while a bisexual identity has been reported in 0.8–1.8% of adult males and 0.8–2.7% of adult females (Laumann 1994; Jorm et al. 2002).

Transsexual prevalence has been estimated at 1 in 11,900–12,900 males and 1 in 30,400–33,800 females (Bakker et al. 1993; Landon et al. 1996; DeCuypere et al. 2007). Transgender identity, including those who do not seek hormones or surgery, may be as frequent as 1:200 (Olysager and Conway 2008).

Prevalence of Mental Disorders in Sexual Minority Subgroups

Because sexual minority individuals are a small subset of the general population, and major mental illness occurs in a smaller subset of that group, it can be difficult to obtain adequate samples for study (Cochran 2001). LGBT subgroups may have distinctions that are blurred when these groups are aggregated in attempts to increase sample size. Almost all studies of mental illness in LGBT populations focus on the most prevalent disorders—anxiety, depression, and drug abuse (Regier et al. 1993). Yet, many community psychiatrists treat chronic, disabling illnesses such as bipolar disorder and schizophrenia.

Samples may not be representative when a segment of a stigmatized subculture remains hidden. And, as social attitudes evolve and civil protections continue to materialize for sexual minorities, the relevance of findings from studies just a few years old may be questionable. Convenience sampling, a tendency to publish studies with positive findings, and political influence over government-related funding sources can also bias who is studied and which studies get funded and published.

With these limitations in mind, increased rates of psychological distress, depression, suicide, and alcohol abuse have been reported for gay men and lesbian women (Saghir et al. 1970a, b; Pillard 1988; Gilman et al. 2001; Cochran and Mays 2006). Gay and bisexual men are reported to have elevated rates of panic disorder, body image and eating disorders, while lesbian and bisexual women are reported to have elevated rates of generalized anxiety disorder (Cochran et al. 2003). Elevated suicide risk is a consistent finding (Cochran and Mays 2006; Gibson 1989; Herrell et al. 1999; Skegg et al. 2003). Most, but not all studies, find the highest rates of psychiatric morbidity in those with a bisexual identity (Jorm et al. 2002; Warner et al. 2004; Koh and Ross 2006). Multicultural stigmatization increases risk for depression further (Cochran and Mays 1994). The few studies that include psychotic and bipolar disorders report no difference to possibly lower rates of schizophrenia among LGBT males (Pillard 1988; Hellman et al. 2002) and higher rates of bipolar disorder (Pillard 1988; Sandfort et al. 2001; Hellman et al. 2002).

Risk factors contributing to increased morbidity include gender nonconformity, family and social rejection, discrimination, and religious conflict (Remafedi et al. 1991; Proctor and Groze 1994; Meyer 1995; Diaz et al. 2001; Omoto and Kurtzman 2006). A history of verbal abuse or physical assault is common (D'Augelli et al. 2002; Herek 1989). Major mental illness independently carries an increased risk for suicide (Hellman 1996). Despite higher rates of psychological distress, no difference in psychiatric hospitalization rates has been observed (Pillard 1988; Hellman et al. 2002). Higher morbidity in

the bisexual group may be linked to being ostracized by heterosexual and homosexual groups (Volpp 2009).

Estimates of psychiatric morbidity in the transgender community are significantly related to the extent of social ostracism and the challenges of gender incongruence. Rates of psychiatric disorders, excluding gender identity disorder, have been reported to range as high as 20–50% for diagnoses of depression, anxiety, and suicidality, with a range of 26–62% for substance abuse. Elevated rates of eating disorders and body image disturbance have also been noted (Pfafflin 2007).

Most sexual minority individuals demonstrate a predominance of health, psychological strength, and resiliency in the face of social stress. Nonpatient homosexual samples have been found to be psychologically indistinguishable from heterosexual samples (Hooker 1951; Siegelman 1972; Thompson et al. 1971) and sexual minorities successfully achieve in multiple domains (Adams 2006; Morris et al. 2001; Saghir 1970a, b; Hart et al. 1978; Smith and Gray 2009; Weinberg and Williams 1974). Social support and safe environments reduce and prevent psychiatric morbidity in transgender individuals (DiFulvio 2004; Sausa 2005).

Understanding Clinical Work with LGBT Patient Populations

The following sections provide an overview of core areas for assessment and specific attention when developing treatment goals with LGBT individuals who present in community psychiatry settings, as well as recommendations for developing culturally appropriate psychiatric programming.

LGBT Identity Development

LGBT individuals with mental illness present to community psychiatrists at different phases of minority identity development (Cass 1979; Troiden 1989; Coleman 1990; Grace 1992; Weinberg 1972; Ritter and Terndrup 2002). To summarize, almost all LGBT individuals are born and raised in heterosexual, cisgender environments. Although not invariable, an early, virtually unconsciousness sense of being different results in the development of self-protective defenses. This is less influential when the environment is supportive and inclusive. Efforts to conform to the dominant social expectations of families and communities results in intrapsychic conflict as same-sex attraction or transgender convictions emerge. Stigmatization, alienation, isolation, shame, and fear can hinder the maturation of sexual identity and social competence, nurturing protective efforts at deception and reactive perfectionism.

In those developing a bisexual identity, confusion is associated with the experience of a dichotomous gay-straight world that is perceived to be negatively biased towards them and monogamously inclined—the heterosexual world believing they are closeted gays, the gay world resenting or ignoring their heterosexual interest, and potential partners of either sex suspect of outside interest or mate sharing. Legalization of polyamorous bisexual commitments remains a taboo in the new era of same-sex marriage.

The internal nature of sexual orientation contrasts with the deep link between subjective gender experience and its external physical manifestation in those with emerging transgender identities (discussed later in this chapter). Transgender individuals must also contend with sexual orientation.

A lack of authenticity, and its psychological toll, leads to exploration of a more genuine experience of intimacy and social presentation that serves to integrate behavior, appearance, and identity. A period of separation from the predominant culture, whose beliefs and values are now questioned, necessitates a degree of distancing from family and community-of-origin as a minority subculture is explored and internalized. Support and acceptance from the minority subculture instills pride, confidence, and enhanced self-esteem. Sexual identity progressively synthesizes with other aspects of identity as a process of coming out occurs and a reintegration into the larger world begins.

Ethnicity, race, and other cultural characteristics contrast with sexual identification, which is

typically not a trait shared with family and community-of-origin. These cultural hallmarks are, therefore, subject to a process of reconciliation with sexual identity. When successful, the process promotes a balanced, multicultural identity. On-going cultural conflict, however, can increase psychiatric vulnerability.

Assessing Sexual Identity, Sexual Practices, Marital and Familial Status

Ascertaining sexual identity involves the collection of information on the patient's core, subjective conviction of being male, female, or androgynous, the gender(s) of sexual attraction, and the degree of comfort in the gender role. Because self-identification as "gay," "straight," or "bi" is often a statement not only about sexuality, but of cultural subgroup affiliation, it may differ from actual sexual behavior, or the frequency and intensity of sexual desire, erotic fantasy, or romantic interest.

A single question on sexual identity is, therefore, likely to yield incomplete or misleading information. A repertoire of questions, with knowledge of their pros and cons, yields a more accurate characterization. A sampling of introductory questions below will help clinicians develop this repertoire.

Box 1 Creating Dialog

1. I am going to ask you some questions about your sexual health that I ask all my patients. They allow me to know more about how to keep you healthy, and your answers are strictly confidential (Potter 2010).
2. Do you have any concerns about your sexual or gender orientation, or sexual practices?
   - To clarify gender orientation: Sometimes people have an issue with being male or female…
   - Have you ever desired to be a member of the opposite sex? *If yes*, what pronoun ["he" or "she"] do you prefer? Would you like me to use that?
3. Has your sexual experience been with men, women, both or neither?
4. What is your sexual orientation?
5. Have you felt sexually attracted or fantasized about men, women, or both?
6. Have you been romantically involved with men, women, or both?
7. Have you been involved with anyone in the past year? *If yes*, what kind of sex did you engage in—oral, vaginal, anal, mutual masturbation? Anything else?
8. Are you using protection, like condoms?
9. When did you last have unprotected sex?
10. How many partners have you had in the past year?
11. Do you have any children?
12. The people who come here sometimes have preferences regarding therapists, e.g., male or female, Hispanic, African-American, gay, etc. Do you?
13. Tell me about your life from a gay [lesbian, bisexual, transgender] perspective.
14. Have you previously had psychiatric treatment?
    - *If yes*: What was that like from an LGBT perspective? Did you feel comfortable and supported?
    - How has mental illness affected your life as an LGBT person?
    - Are there any LGBT concerns that you would like to address here?

Questions targeting sexual experience with males, females, or both can be expanded to inquiry about age of occurrence, frequency, circumstance, and concerns about sexual practices and risk for sexually transmitted diseases. About half of LGBT patients with severe mental illnesses report having no sexual partner in the past year (Hellman et al. 2002). For those who lack sexual experience or partners, questions that focus on sexual interest, desire, or appeal are more appropriate.

What we think we know about LGBT sexuality often derives from common stereotypes in the media. Furthermore, there is a gender divide in

terms of public acceptability. Portrayal of lesbian interest in mainstream, commercial advertising has become acceptable, but a similar interest between men continues to be perceived as offensive (Hooten et al. 2009). These notions of LGBT sexuality are heterosexist in their origins. Assumptions about LGBT sexuality are subject to projections of some proxy for heterosexual, genital–genital intercourse, and gender role stereotypes. LGBT people may even question their own erotic interest because they have internalized these assumptions. The attainment of a self-defined, authentic, erotic identity that can be experienced in sexually safe ways is a more appropriate framework for an open-minded exploration of the contribution of sexuality to general mental well-being. This is also an opportunity to explore issues in common with other psychiatric patients, such as sexual side effects of medication, and the lack of privacy and autonomy for some in residences and other living arrangements.

Assessment of romantic interest, emotional attachment, relationships, and commitments expands on the context of sexuality. LGBT patients may present with no marital history, a history of heterosexual or same-sex marriage, civil unions, domestic partnerships, and commitment ceremonies. All live in a world of opinions and emotions evoked by the changing legal and social status.

As well, child rearing is a growing aspect of the LGBT story. A study based on the 2000 Census, for example, found that children were reported to live in the household of 69% of black, heterosexually married couples, as might be expected, but 61% of black female and 46% of black male, same-sex households were also raising children (Frazer and Dang 2004). Marital alternatives, offspring and child rearing should be clarified with the same inclusiveness that applies to the overall assessment.

Clinical Cultural Communication with LGBT People

The social exchange between the physician and the LGBT patient is influenced by the beliefs and expectations of both. This complex, multicultural dyad influences the session bilaterally, facilitating or constraining the clinical process.

It is the responsibility of the physician to be alert to the multicultural nature of the encounter–and to be able to sensitively understand and address barriers. Self-reflection, discussion, and supervision ensure a more productive interaction, especially when barriers operate unconsciously. For example, if a gender atypical patient evokes a negative stereotype in the mind of the clinician, the physician may deny or minimize the issue in an attempt to maintain harmony in the session, but unconsciously maintain distance by ignoring aspects of the patient, withholding compassion, shortening sessions, and providing less care. Self-reflection and discussion can provide insight into this process of marginalization, transforming barriers in the clinical relationship into opportunities for an empathic partnership.

LGBT patient–clinician interaction can evoke personal issues that can affect the social exchange. What is the patient assuming about the clinician's sexual and gender orientation? Should this be disclosed, and if so, how and when? Does the relationship with colleagues and the culture of the psychiatric institution influence disclosure (Hellman 2011)? What past experience and issues are evoked from the clinician's personal background during the encounter? Do personal traditions, assumptions, beliefs, and moral values conflict or agree? Is this creating barriers to a productive treatment alliance?

Cultural competence is an ideal to aspire to throughout a professional career. First and foremost, the clinician enlists as a community psychiatrist to help others. A humane and compassionate approach with the LGBT patient is as necessary as technical prowess in eliciting and treating symptoms. Connecting with LGBT patients so that they feel comfortable, safe, understood, and supported in an environment that allows them to flourish takes time, learning, supervision, experience, self-reflection, and an institutional effort to provide an inclusive and affirming environment.

The cultural match between the clinician and the LGBT patient is based on the extent of shared cultural knowledge, experience, and identity.

Homophilic relationships, in which the clinician and patient share cultural characteristics, tend to elicit a sense of implicit trust and identification that can enhance a treatment alliance (Rogers and Bhowmik 1970). However, some patients with significant, internalized forms of homophobia may be clinically more comfortable in a heterophilic relationship. In this situation, there is a risk that cultural identity development will be inhibited if the clinician also shares significant, internalized homophobia.

Lesbian and Gay Male Issues for the Community Psychiatrist

The diversity among lesbian women and gay men warrants caution in formulating a clinical approach based on simple characterizations of these groups. In general, gender differences in rearing, socialization and physiology, stereotypes of gender and gender expectations, and gender-based differences that are reinforced in same-sexual erotic, romantic, social, and parental interactions differentiate these groups.

Affirmative psychotherapies help lesbian and gay individuals address homophobia and heterosexism, phases of sexual identity development, life cycle issues, and multicultural conflict. Initial assessment determines the extent to which these issues will be a focus of therapy or will just provide a context for it (Falco 1996).

Bisexual Issues for the Community Psychiatrist

Because bisexuality is commonly perceived in relation to the polarity of homosexuality and heterosexuality, caution is warranted in clinically viewing bisexual patients as being in an incomplete, transitional state between the two (Div 44 Guidelines 2000; Diamond 2008). Stereotypes regarding promiscuity, relational commitment, and community affiliation must be weighed against actual reports of sexual confusion and conflict (Mohr et al. 2009; Weinberg et al. 1994).

Dimensional aspects of core sexual identity are underscored in this group. For example, there is a greater tendency to leave sexual identity unlabelled due to fluidity in sexual boundaries (Diamond 2008). Higher rates of bisexual *behavior* (and HIV risk) are reported in black and Latino men, because the stigma of homosexuality in these communities more often results in disavowal of a gay *identity*. Internalized homophobia results in lower rates of disclosure to female partners. Lack of cultural affiliation with the gay community, and aloofness within the heterosexual community, enhances the risk of isolation and lack of support (Jeffries and Dodge 2007).

Successful bisexual commitments are predicated upon open communication regarding sexual and emotional expectations and mutually agreed upon rules regarding outside contacts (Deacon et al. 1996).

Transgender Issues for the Community Psychiatrist

The desire to be a member of the opposite sex unites a diverse group under the umbrella of transgender phenomena. Transgender individuals may be heterosexual, bisexual, or homosexual. Transgender females and males are, respectively, biological males with a female identification, and male-identified biological females. Some have a mixed gender identity and may refer to themselves as "genderqueer" or "two-spirited." The term "transgender" is broader than "transsexual" because it includes those who do not necessarily transition with hormones, electrolysis, or surgery.

Physical alteration of the body can be an expensive process. Affordability, rather than subjective desire, can be the determining factor in transitioning. Clinicians may, therefore, see individuals born as males, for example, who state that they subjectively identify and live as a woman with a penis or prostate. Some, with transvestic fetishism, are heterosexual and are initially comfortable in their gender of birth. They cross-dress for erotic arousal, but become progressively uncomfortable in their anatomical gender, as the erotic element fades and a cross-gender identity intensifies.

Distress related to gender incongruence is known as gender dysphoria. It can be intense and

persistent in some but not others. When genital surgery is desired, it is typically the culmination of a process that includes living as a member of the opposite sex, maintaining cross-gender hormonal treatment and possibly electrolysis, breast alteration, and facial augmentation. There is no psychiatric intervention known to change gender identity.

Clinicians are not likely to see many of these individuals based on prevalence; however, gender atypical individuals face harassment, stigma and discrimination, gender dysphoria, and the significant challenges of gender transitioning, all which can motivate a need for help. Because cross-gender identity is rare, transgender individuals are frequently concerned that they will not get appropriate mental health care in a mainstream community setting. Psychiatrists treating transgender individuals should be familiar with the Harry Benjamin Standards of Care for Gender Identity Disorders, which provide guidelines regarding diagnosis, evaluation, and documentation for transitioning, aspects of psychotherapy, education, and follow-up care (The Harry Benjamin International Gender Dysphoria Association 2001).

In some transgender individuals, hormone therapy not only facilitates a gender transition, but also diminishes anxiety and depression without the need for standard psychotropic medications. Because cross-gender hormone therapy is associated with irreversible physical changes, medical side effects, and occasional affective lability or depression, it should only be administered by physicians who are thoroughly familiar with its risks, benefits, and management. Most psychiatrists will, therefore, want to refer to an endocrinologist or gender specialist when hormones are a consideration (The Harry Benjamin International Gender Dysphoria Association 2001; Gooren and Delemarre-van de Waal 2007; Wassersug et al. 2007; Oriel 2000).

Careful facilitation must be balanced against unnecessary policing of a gender transition. Psychiatrists not familiar with cross-gender issues should refer these patients to a gender clinic or specialist, but may, otherwise, address standard psychiatric issues. For those from a group that is so often perceived as an oddity, a respectful approach to the transgender patient as a distinct and whole person is crucial (Ophelian 2009).

Building Effective Programs for LGBT Patients

From a specialization that once saw its mandate as changing sexual orientation, psychiatry now finds itself exploring and developing effective models of LGBT healthcare delivery. The process does not have to involve additional funding. Start with the resources you have. Who is interested? Who already has experience and training? Which space, on what days, and which hours can be designated as a safe and confidential place for groups, socialization, and other activities?

Patient presentations differ, demographics vary, staff exhibit all levels of training, interest and comfort with LGBT issues, programs differ in size, purpose, resources, and interventions, organizational cultures vary, and the list goes on. For these reasons, successful programming requires strategic planning.

It is recommended that staff and administrators meet to discuss the strengths and weaknesses of their organization as a resource to the LGBT patient and community. Established criteria for LGBT clinical competence can be reviewed, and time frames set to achieve specific goals. Feedback from LGBT consumers, either informally or through an LGBT consumer advisory committee, and consultation with experts in the LGBT community can provide valuable feedback.

Articulation of an ideal vision of what the organization would hope to become, for example, a limited goal of developing an LGBT competent consultation-liaison staff, or a comprehensive one, such as a regional resource to LGBT people with major mental illness, sets the organization on a path with a purpose. A statement of mission conveys how this would be done, say by the provision of culturally sensitive, core psychiatric, psychosocial, cultural, peer, and advocacy services to LGBT patients, or perhaps, simply, a bimonthly meeting on LGBT issues.

Promotion of the vision by leaders in the organization, and the achievement of benchmarks as the mission is operationalized, helps the culture of the organization evolve as staff and administration witness the benefit to patients, experience enhanced professional pride with staff development, and realize greater institutional stature as the organization becomes a resource to the LGBT community (Burkhart and Reuss 1993).

Because LGBT patients are a minority in mainstream settings, comprehensive clinical programming may only be justified on a regional basis, in contrast with cultural competence, which should be a goal in all settings. When the number of LGBT clients in the clinical setting is low, realistic service provision may only be possible on an individual basis. Programs of any size can designate interested staff as first-line referral resources. Over time, with on-going in-service education and discussion of cases and issues, the competence of all staff will be enhanced and staff resources will widen. Individual LGBT patients can be encouraged to connect with others through support and advocacy websites such as rainbowheights.org.

Practical Programming Suggestions

Objectives ensure that the mission to deliver effective LGBT services will be achieved. Objectives provide an umbrella for specific actions that must be taken through a series of concrete tasks. The box below describes some useful objectives and tasks.

Box 2 Creating Culturally Competent Programming

1. Reduce LGBT patient ambivalence, anxiety, and fear of mainstream settings (create an inclusive setting).
   (a) Post a nondiscrimination of service notice in public spaces.
   (b) Include definition of families/significant others in policies—same-sex partners and parents, domestic partners, spouses.
   (c) Create a culturally inclusive brochure for the waiting room.
   (d) Put up an LGBT poster in the waiting room.
   (e) Provide intake materials for patients that encourage sharing concerns with the assigned clinician about sexual orientation and gender (Cooper and Roter 2003).
   (f) Include gender identity/expression and sexual orientation in Patients' Bill of Rights.
   (g) Involve same-sex partners or a key, supportive LGBT friend in care.
   (h) Broaden concept of "family" to include anyone that plays a significant supportive role.
2. Create an inclusive staff environment
   (a) Post nondiscrimination statement regarding staff hiring inclusive of sexual and gender orientation/expression.
   (b) Review methods of inquiry about traditional and nontraditional family arrangements.
   (c) Canvass clinical staff regarding LGBT knowledge, clinical experience, cultural affiliation, and interest as first-line referral sources and enhance diversity of the workforce.
   (d) Provide supervision on LGBT cases, quarterly in-service staff educational presentations, LGBT journal discussion groups, LGBT case conferences, discussion and supervision regarding clinician bias.
   (e) Enhance the cultural competence of ancillary staff by meeting regularly with ancillary staff; reviewing use of gender neutral terms; reviewing strategies for fielding telephone inquiries; maintaining confidentiality in public areas; policies for use of bathrooms for transgender clients; having inclusive language in intake forms.

(f) Include same-sex partners at social functions.
(g) Meet and review diversity issues once a year.

3. Empower LGBT consumers
   (a) Create an LGBT consumer advisory committee.
   (b) Recruit and train LGBT peer specialists for support, connection, and advocacy (Lecomte et al. 1999; Salzer et al. 2010).
4. Establish affiliation with the LGBT community
   (a) Invite an LGBT representative onto the community advisory board to guide inclusiveness, nondiscrimination, enhance cultural competence, and facilitate community referrals.
   (b) Clarify racial/ethnic profile of local LGBT community and develop staffing reflective of the profile.
5. Facilitate LGBT sociocultural activities
   (a) Organize a "Gender Day" event with transgender speaker presentation, discussion group on gender expression, have a Gender Party.
   (b) Organize a "Lobby Day" event, arranging for LGBT consumer group to meet with government representatives who will impress legislators with importance of funding LGBT inclusive care.

Conclusion

This chapter provides an overview of essential information for the community mental health clinician treating lesbian, gay, bisexual, and transgender patients. The evidence-based literature in this area is rapidly expanding, but it is not necessary for the community psychiatrist to know everything about LGBT people and culture in order to engage this population. It is necessary to know how to create an inclusive, friendly, respectful environment that can promote trust, put the LGBT patient at ease, and allow for the development of a dialogue that enhances the likelihood that relevant and sensitive information will be elicited and addressed. Standards of care for LGBT patients are now widely available and should ease the clinician's task of acquiring the requisite background.

Community psychiatry has progressively shifted in its views and obligations towards sexual minorities. This evolution continues as knowledge of LGBT persons, and the most effective ways to help them, deepens. The process of collaboration with LGBT patients is far from a narrow specialization, because it helps to define who we are, both professionally and personally, challenging foundational assumptions about human identity and behavior, while testing our ability to connect. It is work that expands our understanding of human experience, as we organize ourselves in the best way possible to enhance the well-being of those we serve.

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38 Child and Adolescent Community Psychiatry

Charles Huffine

Introduction

The practice of child and adolescent psychiatry, when done well, can be said to be inherently community psychiatry. Child and adolescent psychiatry covers biological growth and psychological development, but its focus is also on social development. Children are born into families. How a family receives a child and adapts to changing social needs as the child is nurtured toward adulthood is a prime determinate of a young person's mental health. Child development from the earliest months involves dealing with strangers, discovering peers, learning to share, learning to learn by sitting still at school, coping with the social aspects of puberty and eventually developing ever more capacity for autonomy within the larger social order. All such developmental steps are imbedded squarely in family and community.

In the year 2001, the Surgeon General, David Satcher, reported that slightly more than 20% of children and youth, aged 9–17, in the United States have diagnosable mental health issues (US Public Health Service 2000). The diagnosis of depression in teenagers was estimated to be as high as 8.3% (Anderson and McGee 1994). In its 1998 report, the Center for Mental Health Services estimated that 9–13% of 9- to 17-year-olds had serious emotional disturbances, and 5–9% had extreme functional impairments with higher incidence in adolescents. Comorbidity was found to be common in epidemiological studies of mental health disorders in children. Those with depression had associated anxiety, disruptive behavioral problems, and substance use disorders (Angold and Costello 1993). Race and ethnicity may correlate as risk factors for mental health problems due to the association of minority status with poverty, distressed neighborhoods with high levels of violence, punitive immigration laws, and lessened educational opportunities (US Department of Health and Human Services 2001). It has been found that very disturbed children obtained services at an early age, but from multiple providers and with uncertain access to quality or comprehensive services, worse for certain minority children (Mendenhall et al. 2011).

There are differing perspectives on treatment of children's mental health problems. In a recently published book on psychotherapy edited by Norcross, Shirk and Karver (2011) reported on the effectiveness of psychotherapy as based on an alliance with a child or youth. A number of well-researched practices have established their validity as evidence based. In a university-based system, practices were found not easily transferable to community based settings (Weisz et al. 1998). The Evidence Based Practice Institute at the University of Washington has trained line staff at community mental health centers

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focusing on treatments that are less complex. At the Surgeon General's Conference in 2000, promising practices in child and adolescent psychopharmacology were noted, but there was no definitive research on effectiveness or safety for children and youth using psychotropic medications (Jensen et al. 1999). Since Jensen's article, there have been preliminary reports indicating the safety of SSRI antidepressants and other psychiatric medications for children, but this area of treatment remains controversial.

The demand for child and adolescent psychiatrists far outstrips the supply. A report by the US Bureau of Health Professions (2000) projected a need in the year 2020 for 12,624 child and adolescent psychiatrists, but a supply of only 8,312. There are slightly more than 7,000 child and adolescent psychiatrists practicing in the United States. In 1999, the Surgeon General reported that "there is a dearth of child psychiatrists." Only 20% of emotionally disturbed children and adolescents received any mental health treatment, a tiny percentage of which was performed by child and adolescent psychiatrists (US Public Health Service 2000). Psychiatrists working with children and adolescents need to be able to create effective care for individual patients in treatment settings where they likely will not have either the resources or the necessary leadership authority. This chapter intends to provide an overview of how those with an interest in community psychiatry can readily find relevant work in child and adolescent psychiatry.

The Nature of the Practice of Child and Adolescent Psychiatry

How Community Oriented Child and Adolescent Psychiatrists Might Relate to the Community They Serve

There are many venues for the practice of child and adolescent psychiatry. Where one practices, or the nature of the clinic, matters less then whether one is able to assure that the core supports for a psychiatric assessment and treatment program are in place. Funding and time are critical issues to consider when choosing a practice setting. Understanding the needs of children, youth, and families, and assuring one can meet those needs is a primary task of choosing a practice setting. It matters most to one's patients that their doctor stays in the same practice over a long period of time. Continuity of care may be contrary to the conventional notion that the role of the psychiatrist is very temporary in the life of a child or youth. A community is served best when psychiatrists, familiar to a youth and their family, remain accessible at their agency, or are still in their private practice.

Mental health professionals must observe their limits regarding their own privacy and respect the privacy of patients and their families. It is a psychiatrist's job to honor how their young patients want to deal with the relationship with their doctor in different situations. Confidentiality remains a central issue. There are always ambiguous confidentiality issues when dealing with teachers, probation officers, social services officials, drug and alcohol programs, and at times even primary care providers, even when release of information forms are signed. It is important to speak with one's patient and their family to clearly delineate the limits to information sharing. When guided by one's primary relationship to the youth and their family one can at times play a meditative or supportive role with other involved professionals. It is unethical for the psychiatrist to reveal the nature of their relationship when they run into their patient with friends at the mall. The youth can, however, and often do explain their treatment to their amazed peers while hanging out at the mall and bring the group of youth to meet their doctor. When patients want to reveal their relationships with their counselors and psychiatrists openly and with enthusiasm that must honored as well.

It is artificial to regard oneself as aloof from the community in which one lives and works. Anonymity is an illusion. The alternative is to embrace one's role with children and youth and identify as being "of the community" and a positive force for mental health. While never obliged to have out of office involvement with patients, it can be very effective in treating children and

youth to accept invitations to see a school play or musical performance in which one's patient is participating (Martinez 2000). It is common for youth to bring in a friend or group of friends to a treatment session. Inviting them in and learning of a friend's perspective on the patient can be as instructive as speaking to parents or other adult family members. Of course, there are young patients who behave in exactly the opposite way and turn away as soon as they have made eye contact in public and who have a need for complete privacy. That should be honored as well.

Youth have much to teach their mental health practitioners by sharing in an alliance with their psychiatrists and therapists in sessions. They share what is happening in their communities: They talk about the extent of drug and alcohol abuse by peers, they inform us of the nature of youth crime, be it shoplifting, or who is involved in selling drugs. They tell about their peer community's attitudes regarding parties, sexual activity, and the mental health problems of their peers. Often, one can get corroborating information unsolicited by different patients from the same community. It is crucial to respect this information and the youth's willingness to trust their psychiatrist with it. Though one may not reveal youth sources, such information can make practitioners more current and helpful to other patients due to such knowledge (Shirk and Karver 2011).

Understanding the community and social context of the families, children and youth with whom one works is as essential for a child and adolescent psychiatrist as getting a personal mental health history, or a mental status examination. Awareness of community trends, how youth cope with risks, and how they take advantage of social assets can be more readily learned in settings where one can afford to take more time with the youth one sees. Enough time is essential, but payment for such services is often lacking. These tensions are a set feature of the practices of community oriented child and adolescent psychiatrists.

Being actively involved in the community in which one practices outside of one's office can be a way of enhancing one's role as a community psychiatrist. Serving on boards of youth centered programs is an enhancement of one's role in the community. Involved psychiatrists may find they are knowledgeable regarding the ways youth might relate to program enhancements, or how youth may respond to changes in programs. This expertise might translate well on boards of community service agencies, or in mental health related political activities.

The Harsh Realities of the Agencies in Which We Work: Funding, Efficiencies, and How to Make Positive Changes

There are many changes occurring in the practice of child and adolescent psychiatry. The cost of medical education often determines where young practitioners can work. They feel they must find a job in an agency (large "for profit" corporations or community mental health centers which are mostly private nonprofits) that can provide them the means to make payments on their loans as well as provide for their own growing families (Kim 2003). The pressures for efficiency of many such jobs emphasize the more narrow roles of diagnostician and purveyors of medications. Often, other mental health professionals provide psychotherapy and case management. Young child and adolescent psychiatrists are not able to develop psychotherapy skills in such work settings. They may have been allotted grossly inadequate time with patients for doing the core tasks of evaluation and medication treatment as they were taught in their residencies (Honberg et al. 2011). Finding themselves in such a dilemma is the beginning of their education on how social and community factors determine the provision of health care and their role in how to make the system work for them and their clientele.

Public psychiatry and true community psychiatry are not synonymous. A child and adolescent psychiatrist can work in a public mental health setting and stay stuck being essentially nothing more then a conveyor of medications to children and youth after abbreviated evaluations. They may have no role at all in collaborative efforts with other agencies and may never get a chance to know their patients, their families or the social and

community context of the child's or adolescent's problems. Much has been written on how patients are not well served by such high volume and/or underfunded agencies, and how psychiatrists stuck in such jobs are bound to burn out. Such jobs should be either avoided or tolerated only because there is an administrative commitment to change and the psychiatrist has been invited to be part of the process of making the changes.

Child and adolescent psychiatrist can and do shape their practices in agencies so that they can carry out the critical functions of a complete evaluations of a child and their family context. They assess their patient's strengths and developmental status. Many child and adolescent psychiatrists employ strategies of leadership in their agencies. They take interest in administrative problems and use their creativity to collaborate in developing a more effective and efficient treatment system (American Association of Community Psychiatry 2010). They learn to do this in alliance with the other mental health professionals in their workplace. Leadership can be informal, yet very effective when providing consultation and support to other professionals. Child and adolescent psychiatrists are valued on teams when they share their knowledge and are relevant and relatable. Early career child and adolescent psychiatrists may feel deficient in their knowledge of certain realities of caring for service users in public agencies. Joining with line staff in such agencies will very likely provide them a postgraduate education in community factors critical to their patients, particularly those who live in poverty, are subject to discrimination based on race or other social factors, and are traumatized due to exposure to violence in their home and communities (Chenven and Bradly 2003).

Private Practice in Community Psychiatry

Many in child and adolescent psychiatry believe that private practice is not viable financially. If one practices in a group that has a sophisticated billing function, the opposite is true. The irony is that because remuneration tends to be better in private practice then in agency work, it may be possible in that setting to absorb some lower paid hours devoting them to a more active community psychiatry style of practice: visiting schools to deal with the social and academic problems of one's patients, helping families deal with juvenile courts, addressing parenting issues that can avert marital tensions and domestic violence. It is also a context in which psychiatrists can develop psychotherapy skills that integrate well into the myriad of social and community issues facing child and adolescent patients. Those working with youth experimenting with drugs and alcohol must develop strategies in how to manage confidentiality and motivational techniques in the service of harm reduction. They also must have working relationships with substance use disorder treatment programs in their community. Private practice can be a context for getting to know a great deal about one's community. Youth let a therapist with whom they have an alliance know where the drug dealers are most available, what happens at parties where there is excessive drinking and sexual misbehavior, and what programs work for a certain kind of youth so that one can develop a wealth of community resources for one's patients (Shirk and Karver 2011). Ironically, these opportunities within private practice may enable one to better practice community psychiatry.

The Child and Adolescent Service System and Ways That Child and Adolescent Psychiatrists Contribute: System Elements

When one looks at the service network for children and youth whose psychological development goes awry, one discovers an army of professionals engaged in helping young people get on track. Child and adolescent psychiatrists must understand where their skills fit within this network of services. They are assets for the system of care when deployed in thoughtful ways, either as consultants or staff psychiatrists. The following are examples of elements of such systems and delineate the potential relationships that can be developed.

Primary Medical Care: Infant Mental Health, Services for Individuals with Developmental Disabilities and Youth with Psychiatrically Based Problems

Primary care physicians (PCP's) get involved with families with babies from the moment of birth. We expect them to be sensitive to early childhood mental health issues that often appear first in a PCP's office. There are a burgeoning number of services focused on infant and early childhood mental health in many communities. Service agencies include maternal and infant care programs, developmental centers, therapeutic preschools, Head Start and other school readiness programs. Cross-professional training programs in infant mental health have devised evidence based practices. They credential professionals from diverse backgrounds to provide such services (Early Childhood Consultation Partnership Bicio 2010; Irving 2009). Child and adolescent psychiatrists have a unique perspective on early childhood mental health due to the depth of their medical training. Thus, they have a unique capacity to support their pediatric colleagues in serving young children in distressed families. Their training and expertise allow them to identify and participate in the care of the most developmentally disturbed children such as those with autistic spectrum disorder, fetal alcohol spectrum disorder, intellectual disabilities, or children born with, or acquire damaged brains. They can join with primary care providers and nonmedical colleagues in the challenge of helping such children with severe impairments find their path to social development and meaningful roles in the community. These team-based approaches are quintessential community psychiatry (Klaehn and Martner 2003).

Consultation and practice through colocation in primary care clinics and telepsychiatry are bringing psychiatric expertise from major centers to rural and underserved urban communities. They are examples of options for organizing better coordination between primary care and mental health in the treatment of children and adolescents. Such activities are solidly in the context of community psychiatry. There are many who have concerns regarding the forms of integration as health care reforms move rapidly following the passage of the Affordable Health Care Act. Many children and adolescents would benefit if mental health care was colocated with their "Medical Home," but others doubt the wisdom of a system that sorts children with brief and minor problems from those who would be referred for secondary services. Many youth may pass in and out of serious episodes thus creating the potential for loss of continuity of care. The Milbank Memorial Fund created a set of paradigms for possible exploration offering solutions to some expressed concerns regarding integrated care (Collins et al. 2010).

Relating to Schools and Special Education

Public schools are, or could be, a public health treasure. Indeed, there was much written about school mental health in the 1960s and 1970s. There are numerous examples of child and adolescent psychiatrists being part of a mental health team embedded in a school or school system who assess youth and help schools accommodate to their special needs (Porter et al. 2003). Individualized Education Plans (IEP's) under the federal Individuals with Disabilities Education Act (IDEA) and Section 504 of the Americans with Disabilities Act (ADA) set the rules mandating public schools must provide optimal education to every child or adolescent with a disability. It is often a child and adolescent psychiatrist who provides schools with the requisite evaluations. In the past, it was common for school systems to hire or contract with psychiatrists so as to meet legal requirements. With funding cutbacks this has become an ever more rare practice (Porter et al. 2003). Distressed families turn to psychiatrists for support in demanding adequate educational preparation for disabled children. Special education programs in school systems may tap into local child and youth mental health facilities as partners in helping the schools with

their difficult task. Psychiatrists, as part of such teams, have a role in the response to schools' requests. Such roles are classic child and adolescent community psychiatry.

Relating to the Social Service System

States, using both state and federal funding, provide for abused and neglected youth who have suffered trauma and neglect that has lead to significant mental health problems. Child and adolescent psychiatrists are an essential part of a mental health team providing special services to foster children, children with parents with domestic violence issues, and children with severe emotional and behavioral disturbances secondary to trauma. Psychiatry has a special role in programs that address the complex psychological and medical problems of traumatized children. Psychiatrists should become aware of social service innovations, i.e., the Mockingbird Family model initiated in Washington State (Theofelis 2010). There are opportunities for employment for psychiatrists in both government run and private nonprofit social service organizations. Child and adolescent psychiatrists so employed are indeed practicing community psychiatry (Marx et al. 2003).

Child and Adolescent Psychiatrists and the Juvenile Justice System

Juvenile justice programs, including juvenile detention facilities, often request consultation and seek evaluation services for youth in their programs. Psychiatrists may play forensic roles in the juvenile justice systems or provide direct services to juveniles in detention as part of the health services team. Forensic specialists may function in a juvenile court setting, helping courts better understand the underlying issues that lead youth to law breaking. Other psychiatrists with rehabilitative roles get involved in developing services for children and youth within juvenile just programs and facilities (Heffron et al. 2003).

Co-occurring Disorders and Drug and Alcohol Programs for Youth

While there is a subset of child and adolescent psychiatrists who become addiction specialists and work within co-occurring disorder programs, almost all psychiatrists serving youth are confronted with managing drug and alcohol issues. They hear from their patients of incidents of gross abuse of substances and subsequent traumas resulting from this behavior such as date rape, automobile accidents, or secondary trauma to youth witnessing grossly disordered social behavior. Some youth feel responsible and guilty for abetting the traumas that have befallen their peers from unsuccessful experimentation. Psychiatrists serving such youth become charged with helping them manage their own risks and their exposure to the chaotic behavior of their peers. Motivational Enhancement Therapy is an evidence based practice which is designed to help youth come to grips with their own vulnerabilities and either reduce their risks on their own or accept evaluation and treatment by chemical abuse and dependency specialists. The developing social tolerance for marijuana, the ubiquitous example of adult misbehavior with alcohol, and the perceived adventure of experimenting with other drugs of abuse create a context where youth feel that they have social sanction to use and abuse drugs and alcohol. Most child and adolescent psychiatrists treating teenagers confront these issues daily. These are social issues that pervade all our communities and demand community psychiatric expertise (Bukstein et al. 2004).

Other Systems: Programs for Homeless Youth, Recreational Services, Jobs Training for Youth, Youth Empowerment Programs

There are numerous other community programs where psychiatrists may find a role; drop in centers for homeless youth, youth athletic programs, parks department or school recreational activities, spiritual based programs, job programs for youth,

and youth empowerment programs. There are a myriad of ways for child and adolescent psychiatrist to interact with programs supporting youth by developing resiliency. Roles for psychiatrists in such youth programs may involve a paid part time role, paid consultation, or volunteer time. All such roles are part of the practice of child and adolescent community psychiatry.

Special Issues in Child and Adolescent Community Psychiatry

The Concept of Systems of Care

The agencies described above, all together, form a system of care. In the past 3 decades, there has been great emphasis on understanding how the system of care works for children and youth and their families. Is it fragmented into silos? Are services coordinated? Must a family having difficulties with their child manage multiple meetings each week with different agencies getting often contradictory advice, or can they participate with all involved professionals as a full member of a team creating a single plan for their child? Child and adolescent psychiatrists with understanding of systems can be a source of support for families in developing collaboration between the agencies involved in getting a troubled youth back on track.

Fragmentation in human services for children led to the System of Care movement. The concept emerged in the mid 1980s as many families angry with fragmented care joined together, first in communities and then nationally (Vander Stoep et al. 2002). The National Federation of Families for Children's Mental Health (NFFCMH) emerged in 1989 through the efforts of parents demanding more coherent systems of care. Ira Lourie, a child and adolescent psychiatrist directing the NIMH in the early 1980s, demanded federal attention to fragmented care for multisystem involved children and youth. He is credited with initiating the Child and Adolescent Service System Program (CASSP). Stroul and Friedman (1986) wrote the CASSP monograph that defined System of Care. They created the values and principles statement widely credited for influencing many communities in the United States to adopt Systems of Care concepts as a "values based practice" (Winters and Terrell 2003).

In 1993 CASSP evolved into the Comprehensive Community Mental Health for Children and Their Families grant program (often called System of Care grants). Nearly 200 programs had been awarded $6,000,000 grants by the end of 2010. Communities in every state came together with memorandums of understanding obligating all elements of the child serving system to meet together at an executive level to facilitate coordinated care. Parents and many professionals became involved in experiments in care coordination. Parents shared their ideas on parent empowerment and family and youth centered care at grant sponsored meetings. Many parents emerged as trainers in their home communities consulting to others including professionals. From such experiments emerged an innovative planning method: the Wraparound Process. This process places parents and older youth in charge of planning for the care they receive for behavioral health problems. They are supported by experienced parents and professional care managers who enable them to meaningfully collaborate with the professionals involved. Wraparound's chief innovation is in mobilizing communities to help a family through inviting extended family, neighbors, community leaders, and other natural supports. Participation in "System of Care" grants has proved to be a transformative experience for psychiatrists who are involved. Numerous measurement tools were devised to evaluate the impact on families and the children and youth who were served by the grant (Friesen and Winters 2003). A unique aspect of the system of care movement was its commitment to the empowerment of parents and youth. The Measurement of Empowerment in Families tool was particularly noteworthy (Koren et al. 1992). The *Handbook of Child and Adolescent System of Care; the New Community Psychiatry* provides a comprehensive overview of the expanding roles for community oriented child and adolescent psychiatrist within systems of care (Pumariega and Winters 2003).

Parent Driven and Youth Guided Care

A key element that makes a child and adolescent psychiatrist a true community psychiatrist is that he/she is committed to practicing system of care principles through empowering parents and youth to be collaborators in their own care. Since the emergence of System of Care principles there has been a growing literature on "parent driven" mental health care for their children. They actively demonstrated how to build a youth empowerment program in their presentations at grant meetings. A System of Care youth movement promoting the concept of youth guided care began at the Surgeon Generals Conference on Children's Mental Health in 2000. A group of youth created a youth manifesto that was read at the final plenary, demanding youth be heard by those administering care providing systems and initiated the youth motto: "nothing about us without us," shortly after the Surgeon General's Conference Youth M.O.V.E. (Motivating Others through Voices of Experience) was initiated by youth under the sponsorship of the NFFCMH. With support from the parent organization and a host of professionals, youth empowerment programs became mandated elements of the System of care grants. The hallmark of System of Care principles applied to youth struggling with a mental health problem is the adoption of a strength based approach. When strengths are identified and celebrated, youth are much more able to address problem areas. A respectful, hopeful, and strength based approach can indeed take into account developmental issues, psychopathology, or the effects of trauma.

What Is Recovery in Child and Adolescent Mental Health; Is the Concept Relevant?

The concept of parents and older youth collaborating in their own care evolved at the same time, but independently, from the adult recovery movement with its emphasis on person centered care, i.e., a respectful relationship between an individual with a mental illness and a psychiatrist or other mental health professional as the service user defines for themselves how to rebuild their life. There has been much discussion about the concept of recovery as it applies to children and youth. Some are adamant that the concept does not apply, some feel that in youth the concepts of "resilience development" is a more germane concept, others feel that an adult concept of recovery provides "value added" to other conceptual frameworks (Friesen 2005) These ideas emerged independently as parents and youth sought changes in mental health services for children and youth. In providing behavioral health care for children and youth, one must always take into account that treatment is aimed at moving targets given that children and youth are moving on a developmental trajectory; what they want in their life may change month by month. However, many youth have suffered setbacks developmentally due to a mental health problem. Problems can alter their trajectory significantly with consequences of maldevelopment and dysfunction. Restoration of a normative developmental process has been identified by some as the essence of a recovery process in youth (Huffine and McLaughlin 2006). The concept of developmental struggles is felt to be more germane to dealing with the problems of youth then using only diagnostics. Developmental struggles embrace temper tantrums and sleep problems of early childhood and the social isolation and school problems of grade school children. It embraces youth seen as having exceptionally poor judgment and youth who go beyond normative experimentation with drugs or sexual experiences. It embraces youth who do not smoothly handle the changing roles of parents as youth emerge as young adults. The Wraparound Process involves parents, or older youth taking the lead in collaboration with an experienced alternative parent figure and a care manager. The team of involved professionals, including psychiatrists, and several natural supports, functions in a respectful interplay with the parents and older youth. In a successful wraparound team, the interactions between the service users and professionals are

identical to the ideal of person centered care, the hallmark of the recovery process. Families and or older youth define for themselves what they want and use professionals as resources in their quest for meeting their life goals.

Relating to Families and Youth: Empowerment Programs for Families

A particularly rewarding aspect of working in a System of Care sophisticated community is the discovery of talented and devoted parent support specialists and an occasional youth peer support specialist. Parents who have "grown up" in the family movement and youth pioneers in the youth empowerment movement have had special training in many states and have practical experience working closely with their peers. They have their frustrations with their marginally funded agencies and are occasionally overwhelmed with the depth of problems they must face as they relate to peers who are in need of support. Such advocates tend to like relationships with psychiatrists if the psychiatrists on their teams seem respectful and relatable. Parent support specialists are often hired in agencies and have very clear roles on Wraparound teams (Huffine and Anderson 2003).

Alliances and Advocacy on Behalf of Youth

In each of these community roles child and adolescent psychiatrists are bound to be working as a team with those from other branches of medicine or other disciplines. Doing this demands a level of appreciation for, and dependence on, our peers. A need for a collaborative approach is not necessarily an attribute of physicianhood. Many are trained that physicians should have the final say on any number of dicey issues that confront treatment teams. Part of the requirement for being a well-functioning community psychiatrist is to have respect for what other disciplines know and can do. It is necessary to understand the need for collaboration and communication with nonpsychiatrist partners as it makes more circumscribed roles possible. It also requires understanding the administrative structure of the programs worked in as well as the rules, the culture, and the funding requirements of agencies.

There are other situations in community based work where as clinicians child and adolescent psychiatrists have insights that demand they take a stand that places them in an advocacy role. They may have to take a contrary view on a social or community issue based on their knowledge and their ethics. Disagreeing respectfully and engaging in thoughtful discussion can sometimes sway opinions in others who are not doctrinaire, or at least may move our colleague to a less automatic, or tightly held belief. Child and adolescent psychiatrists are called upon occasionally to address a community's harmful backlash against perceived rampant teenage misbehavior and to offer a more balanced perspective between parental protection and appropriate risk-taking behavior. Adolescent behavior often stirs up feelings and provides our communities with a perfect scapegoat for all social ills. Those with more repressive or punitive approaches often have undue influence on policies toward youth at a governmental social policy level, or even within the organizations charged with caring for troubled youth. Psychiatrists are ethically bound to oppose policies or practices that may have a negative effect on struggling youth. Such situations demand a finely honed knowledge on how to balance social cross-currents in our communities.

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39 Serving Elders in the Public Sector

Carl I. Cohen and Fayaz Ibrahim

Introduction

Community care of the older adult cannot be conducted in isolation. Whether the community mental health provider orchestrates the care or works as a member of a team, it is important to understand the underlying principles of geriatric psychiatry and be familiar with the resources necessary to provide comprehensive care. The aim of this chapter is to provide the community practitioner with these basic principles, to describe the key community resources for older adults and to present several innovative model programs for addressing mental health needs in later life.

Principles of Geriatric Psychiatry for Community Mental Health Practitioners

1. *Older adults are the most heterogeneous group in the population*. Older persons differ dramatically in their physical and mental health, functional abilities, social networks, political and religious beliefs, and so forth. Although we often categorize aged persons based on chronological age—e.g., the census bureau defines "older adults" as aged 55–64, and elderly as 65 and over—there are marked differences in biological aging. This is especially true among persons with persistent and severe mental illness who may have health problems more characteristic of persons who are 10 or 15 years older. Although older adults are heterogeneous, they do share some common life experiences that may have psychosocial ramifications (so-called "cohort effects"). However, with the increasing number of older persons reaching very old age, the number of cohorts within the aging population has grown. For example, persons born before 1930 came of age during the Great Depression and World War II, whereas those born after the war came of age during more prosperous times that included the cultural and social turmoil of the 1960s. Similarly, the oldest African Americans grew up during periods of marked racial segregation and discrimination, whereas "young-old" African Americans came of age during the period of the civil rights and black power movements.

   Clinical implications: Mental and physical health care to older adults should not be determined solely by chronological age because of the marked diversity within this age group. However, living through similar historical periods can provide a common background context for older adults of the same age.

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2. *The demographics of aging are shifting*. The baby boomers (people born between 1946 and 1964) will first turn 65 beginning 2011. The older population is projected to nearly double from 38 million (12.6%) in 2008 to 72 million (20%) in 2030 (Population Projections, U.S. Census Bureau 2010). Persons aged 85 and over are the most rapidly growing segment of our population and their numbers will double over the first quarter of the century and more than quadruple over the first half of the century (to over 19 million persons). The older population is also growing more diverse. For example, in the 2000 census, 16% of the population was non-White (Blacks, Hispanics, Asians, Native Americans) or 5.8 million persons. In 2050, 36% of population will be non-White or 29.5 million persons. Thus, there will be a fivefold increase in the number of minority elders over the first half of the twenty-first century.

   Clinical implications: Community mental health providers can expect to be working with increasingly older and more diverse populations, and that they must possess appropriate clinical skills and cultural knowledge if they are to deliver competent care.
3. *Assessment is different in older age*. The assessment of older adults must take into account communication difficulties in vision and hearing, physical handicaps, and cognitive difficulties.

   Clinical implications: Clinicians should generally assess cognitive and physical dysfunction on the initial examination, and then continue to closely monitor for the effects of treatment on the patient's mental or physical functioning. Another key difference from younger persons is the likelihood that caregivers, both formal and informal, will be more involved in providing information and treatment.
4. *Disorders may present differently*. Like physical disorders, the clinical presentations of psychiatric disorders may differ in older persons. For example, compared to younger persons, depression in older adults may present with fewer signs of sadness and with more symptoms of social withdrawal, somatic concerns, motor disturbances, and apathy (Blazer 2003). Similarly, late-onset schizophrenia tends to occur disproportionately more in women and to have fewer negative symptoms and no formal thought disorder (Jeste 2009).

   Clinical implications: Clinicians must be vigilant for more atypical symptoms in older adults.
5. *Treatment may be different*. With increased age, there are changes in the absorption rate of medications, distribution of drugs as a result of an increase in adipose tissue relative to lean body mass, diminished metabolism in the liver, and declines in renal clearance.

   Clinical implications: Dosages of medications may need to be lower than in younger persons, and considerations of side effects and drug interactions become more relevant.
6. *The course of disorders may be different*. Schizophrenia shows a diminution in positive symptoms with age, whereas levels of co-occurring depression may remain the same or increase, and mild cognitive problems present earlier in the course of schizophrenia may worsen due to the normal effects of the aging process (Cohen et al. 2008). Depression in later life may present with subtypes (e.g., vascular depression, depression in dementia) that are typically more resistant to treatment, and there is some evidence that older persons with major depression may be more prone to relapse and relapse sooner than their younger counterparts (Blazer 2003).

   Clinical implications: In treating persons with schizophrenia, it is important to be aware of changes in symptoms that occur with aging and to adjust treatment accordingly. In treating older adults with depression, it is important to determine the subtype of depression, because prognosis varies considerably depending on the etiology of the depression.

7. *Aging is characterized by both longstanding conditions and late-onset conditions that may become chronic.* For example, depression in older adults is often chronic, and more than half of persons with depression in later life remain in the syndromally depressed category on 3-year follow-up, and an additional 30% have some residual symptoms in the subsyndromal or subthreshold depression category (Blazer et al. 2009; Cohen et al. 2009a). Even under the most ideal treatment conditions, e.g., medication and psychotherapy, about one third relapse on 2-year follow-up (Reynolds et al. 2006). Moreover, the line between reversible and irreversible illness may become less distinct. For example, late-onset depression may be a prodromal symptom of dementia. It is estimated that two fifths of late-onset depression with cognitive problems (so-called "pseudodementia") may eventually progress to a true dementia, despite there having been an initial resolution of the depression (Alexopoulus 2004).

   Clinical implications: Although treatment can help reduce recurrence and levels of symptoms, the complex interaction of psychiatric and physical conditions may make full recovery less likely. Consequently, while the ultimate goal for all patients may be the remission of symptoms, sometimes treatment goals will have to be adjusted, and like some chronic physical disorders, persons may have to live with a modest level of symptoms.

8. *Nearly all older adults with psychiatric disorders will have comorbid conditions, although not all comorbidity is alike.* Some comorbid conditions can contribute substantially to disability and functional decline (e.g., severe osteoarthritis, severe heart disease, neurocognitive disorders), whereas other conditions have minimal effects on functioning (e.g., controlled hypertension or hypercholesterolemia). There is increasing evidence of a reciprocal interaction between depression and many physical disorders (Blazer et al. 2009). In other words, depression is associated with greater occurrence of physical illnesses, and physical disorders may lead to a greater incidence of depression. Also, depression and anxiety often co-occur, and having more anxiety symptoms is a poor prognostic indicator in depression (Cohen et al. 2009a). One of the more significant health challenges involve persons with some combination of chronic pain, dementia, depression, anxiety, bereavement, multiple losses, social isolation, and poor nutrition (Flint 2002; Sadavoy 2009).

   Likewise, comorbidity is very high in dementia, with approximately one fourth of persons manifesting clinical depression, one half having psychotic symptoms, and one half having agitation or activity disturbances. Depression is also a common co-occurrence in schizophrenia, with rates ranging from 11 to 75% (Cohen et al. 2008).

   Clinical implications: There is some evidence that treating depression can improve health outcomes and that improving physical health can improve depression and anxiety (Sadavoy 2009). Unfortunately, the ability to successfully treat depression is less robust in older persons with concomitant physical disorders.

9. *There is continuity in personality*. Each older person is a product of the lifelong effects of physiological, environmental, and psychological factors. With respect to the latter, although some changes occur across a lifespan, various personality traits (e.g., coping, sense of control, self-esteem, interpersonal skills) tend to be fairly stable over time, and they will affect how one deals with late-life stressors.

   Clinical implications: On the positive side, continuity means that older persons have been able to successfully employ various coping strategies to manage their stressors over the life course (Sadavoy 2009). Consequently, therapists must help to gird up these previously successful coping mechanisms, and in turn, improve the person's sense of self-esteem. However, with

increasing age and disability, previously successful strategies may not work, and therapy must address how to deal more effectively with the physical, cognitive, and social losses that occur in later life.

10. *Psychiatric illness must be understood within a social and biological context.* The importance of material and emotional resources as well as physiological conditions (co-occurring illness, medications) must be considered. It is said that aging is a bit like gambling: the longer you go on, the more likely you are to lose. Thus, older adults have to confront and deal with various losses, perhaps best summarized by the 4Ds of aging: disability, dependency, desertion (e.g., loss of close relationships as people move away or die), and death (e.g., one's own mortality and the death of others).

    Clinical implications: For some adults who are physically healthy and have strong social resources, a useful strategy might be to encourage activities and engagement following losses of kin or friends or in the context of life stressors. On the other hand, for persons with more disabilities and fewer resources, encouraging too much engagement may be unrealistic and further exacerbate their feelings of worthlessness.

11. *The prevalence of psychiatric disorders in older adults and mental disorders are best viewed on a continuum.* A major issue in geriatric psychiatry is whether official psychiatric disorders accurately reflect the degree of psychiatric distress in the community. This stems in part from the fact that many older adults may present atypically, that comorbid physical and cognitive disorders may make fulfillment of the diagnostic criteria more difficult, and older adults with psychiatric disturbances may cluster in certain settings so that they may not be adequately sampled (e.g., natural occurring retirement communities, assisted living facilities, and nursing homes). There has been increasing interest in viewing disorders on a continuum and looking at subsyndromal or subthreshold disorders with respect to depression, anxiety disorders, psychoses, and neurocognitive disorders. This perspective overcomes some of the difficulties using diagnostic categories and it recognizes that many of these subthreshold categories are associated with poor functioning and outcomes.

    Clinical implications: Psychiatric symptoms among older adults are common and may cause dysfunction, even when they do not meet DSM IV criteria. Thus, perhaps even more so than in any other age category, it is important to not overly rely on strict diagnostic criteria and to focus on the clinical symptoms that are causing distress.

12. *It is essential to view the treatment goals for older adults with mental illness in the context of a life course trajectory.* It is now recognized that the outcome for certain symptoms of schizophrenia is more favorable than previously believed. For example, roughly half of persons attain clinical remission as defined as having mild or no symptoms in positive and negative symptoms, and nearly half may attain social recovery (Cohen et al. 2009b). Older persons with depression do less well than previously believed, with roughly half continuing to have clinical depression on follow-up, and perhaps another 30% may have appreciable residual symptoms (Cohen et al. 2009b). Thus, only one fifth may be in full remission on long-term follow-up. However, with more aggressive and creative treatment strategies (see below), outcome can be improved. Thus, for persons with severe mental illness, the ideal life trajectory can be viewed as a process moving from diminishing psychopathology and impaired functioning to normalization to positive health and well-being.

Psychopathology → Community integration → Successful aging

The initial part of this trajectory may be conceptualized as "recovery," whereas the latter part may be conceptualized as "successful aging." The latter can be viewed as a state involving the absence of disability accompanied by high physical, cognitive, and social functioning. It is a state that older adults may aspire towards, but often do not achieve. Even among the general aging population, only one fifth attain "successful aging" (Ibrahim et al. 2010). However, among persons with schizophrenia, only about 1 in 50 persons attain this status (Ibrahim et al. 2010).

Clinical implications: We now recognize that for many persons with schizophrenia, middle and older age is associated with better outcomes than previously believed, and that as some of the more severe symptoms relent, and certain social pressures diminish (e.g., need to have full-time work or marry), it may be an optimal time to make strides toward greater recovery. For older persons with depression, complete and permanent recovery is difficult, and the clinician needs to recognize that depression in later life is often a chronic disorder that requires more patience and clinical efforts than previously believed.

13. *Mental illness in older age is complex*. Items 1 through 12 suggest a high degree of complexity with respect to the interaction of age and mental illness. For example, Flint (2002) observes that in later life there is a complex interaction between depression, anxiety, physical illness, cognitive impairment, personality factors, and life stress. Interestingly, although aging is associated with a multitude of stressful events, older adults do not develop psychiatric disturbances at higher rates. One example is that the prevalence of major depression is lower in elderly persons than young and middle-aged adults (Blazer 2010). Sadavoy (2009) proposes that various stressors—e.g., environmental, physical disease, or life events—interact with personality-based and environmental vulnerabilities (e.g., poor coping strategies, diminished social support, fewer material resources) to induce negative emotional states such as demoralization and fear. These states may further affect physiological mechanisms (e.g., inflammatory responses, adrenocortical activity, and other biological processes) that can lead to more severe symptoms and clinical disorders. However, as suggested above, many elders have physiological, psychological, and environmental resources that modify these processes and avert unfavorable outcomes.

    Clinical implications: In caring for persons of any age, the good clinician must recognize the biopsychosocial factors influencing the mental state. However, in the care of the older adult, each biological, psychological, and social element is likely to be more complex than in younger adults because their longer life has provided more experiences as well as more opportunities for interactions among these elements. Moreover, older adults are survivors, having outlived many of their original age cohorts, and they have strengths that must be recognized along with any shortcomings.

Meeting the Services Needs of Older Adults

The cost of untreated mental illness in the United States is estimated to be more than $100 billion annually, and nearly half of that cost can be attributed to people aged 60 and over (Sisko et al. 2009). Bartels et al. (2003), using Medicare and Medicaid per capita expenses, found that for persons age 65 and over, schizophrenia was among the most expensive disorders, and it exceeded the costs of dementia, depression, and persons with only medical disorders. Moreover, across the life span, expenses for schizophrenia and depression exceeded those with only medical disorders. The authors concluded that innovative models of home and community-based services could reduce costs by decreasing the relatively high use of nursing home placements among persons

with schizophrenia. However, with a sluggish American economy and state budgets being cut dramatically, older adults with mental illness are especially at-risk. The problem is apt to worsen as the number of older adults aged 65 and over with a history of mental illness will rise from roughly 7 million in 2005 to 14 million in 2030 (Office of Mental Health-OMH 2011).

Older adults with mental illness have many unmet needs. *They have a lower rate of service use than adults in middle age and are less likely to perceive the need for services*. An analysis of attitudes about mental health using the NCS-R data found older Americans do not have negative help-seeking attitudes or negative beliefs about the efficacy of treatment for mental health problems. This finding, which is consistent with recent positive views of aging, suggests that enabling resources and perceived need factors, rather than negative attitudes about psychiatric treatment, are more likely explanations for older adults' low rates of mental health service use.

Palinkas et al.'s (2007) survey of various stakeholders regarding the unmet needs for older adults with mental illness identified two interrelated themes: (a) the need for age-appropriate and culturally appropriate services to overcome barriers to mental health services access, use, and quality; and (b) the recognition of unmet needs that address prevention as well as treatment of mental illness, including socialization and social support, transportation, housing, and physical health care. Age-appropriate and culturally appropriate solutions (such as recruitment of diverse staff and training related to diversity) that address both prevention and treatment may represent the best strategies for addressing the challenges of mental illness and were most likely to be endorsed by stakeholders.

While formal and informal sources provided adequate services for certain client needs, over 70% of the clients did not receive the correct type of help for some of their needs (Cummings and Kropf 2009). Greater communication between mental healthcare staff and informal caregivers, and the integration of aging network services, is essential for the adequate provision of care to older severely mentally ill adults. Education and greater linkages among care providers are necessary so that all service providers are aware of and are able to appropriately respond to the complex multilevel needs experienced by older mentally ill adults.

Community Resources and Care

In Table 39.1, we present an overview of the services for older adults based on functional level. On the vertical axis of the table is a measure of independence and self-functioning (mental and physical) divided into three categories: well, moderately impaired, and or severely impaired. On the horizontal axis are three broad categories of needs: physical and mental health needs; self-maintenance needs such as dressing, grooming, cooking, transportation, cleaning, and handling money; and a more complex level involving social needs such as work roles, friendship, intimacy, and education. Thus, for example, a comparatively well older person who has recently lost his spouse might be helped by referrals to mental health services in the top left box and social and vocational services listed in the upper right box of Table 39.3. Similarly, a moderately impaired person with depression might benefit from various services in the middle row of the table.

Description of Community Services

In working with older adults, it is important for community clinicians to familiarize themselves with the various types of community services available to older adults. In Table 39.2, we describe the programs that can be used to address the various needs listed in Table 39.1.

Innovative Model Programs

New community treatment strategies for older adults with mental illness can be divided into: (a) collaborative programs, (b) case management

Table 39.1 Types of services available to elderly individuals

	Physical and mental health needs	Self-maintenance needs	Social needs
Well elderly (60% of population)	Mutual help groups Consumer health education Health insurance Health screening Screening for psychiatric symptoms, substance abuse, and prescribed drug misuse	Shared housing Converted boarding homes ECHO units and "granny flats" Section 8 and Section 202 housing Elderly apartment complexes Retirement community Congregate meals program Nutrition education "Brown bag" programs	Senior center Voluntary association Retired seniors Volunteer program Foster parents and grandparents Senior companions Service Corps of Retired Executives Senior aides Adult education
Moderately impaired (30% of population)	Outreach services Visiting nurse Crisis intervention teams Collaborative care programs Problem-solving techniques (PST)	Case management Home care services Congregate housing Foster care Vocational rehabilitation Assisted living Board and care homes Congregate housing Meals-on-Wheels Transportation services Escort services Chore services	Friendly visiting Telephone reassurance Strengthen informal social network
Severely impaired (10% of population)	Multiple help groups for family Outreach services Visiting nurses Crisis intervention teams Inpatient psychiatric and medical care Collaborative care programs	Day care Respite care Home care services Hospice Nursing home Meals-on-wheels Protective services Case management	Friendly visiting Telephone reassurance Strengthen informal social support network Social skills training

ECHO Elder Cottage Housing Opportunity
Source: Modified from Cohen and Boran (2004)

strategies (c) Some combination of (a) and (b). Collaborative initiatives that integrate mental health, primary care, and pertinent community supports have the potential to ease the accessibility issues faced by older adults and to foster cross-discipline/cross-sector knowledge transfer to address complex situations (Horgan et al. 2009a). Case manager strategies typically use persons with clinical backgrounds to provide guidance, counseling, and skills training to older clients as well to promote appropriate care by primary care providers and interdisciplinary communication. The principal focus is on improving outcome of care.

Much of the focus of collaborative care programs and case management approaches has been directed at primary healthcare providers. For example, the World Health Organization (2003) asserts that the treatment of common mental disorders such as depression should be done in primary healthcare settings. Several writers have argued (Blount 1998; Lester et al. 2004) that the integration of health and mental health care within primary healthcare settings is the best option for psychiatric care and that these settings may be the logical sites for "medical homes" for persons with mental illness. Some of the reasons for focusing on primary care settings is that they

Table 39.2 Principle community services for older adults assistance and protection

Information and referral (assistance) services	These activities are coordinated through the Administration on Aging (AOA) and provides for each state to designate an agency for aging services. In some states, an independent office on aging has been established; in the remaining states, aging programs are part of a human services department. In most states, aging agencies designate smaller geographic service centers, termed area agencies on aging (AAA), to provide local communities with information and referral services. There are also a variety of voluntary and private resources that provide information and assistance, e.g., family services agencies, senior centers, mental health associations
Case or care management	The primary aim of traditional case management is to help clients and family deal with a fragmented and complex system by locating and coordinating existing resources through a process that includes screening, assessment, case planning, linkage to services, advocacy, monitoring, and behavioral health. More recently, care managers are being used as part of a therapeutic team for psychiatric patients and may involve direct counseling, collaboration with primary care providers, and coordination of services (see text for examples)
Adult protective services	These services serve persons who are: incapable of performing functions necessary to meet basic physical and health requirements, incapable of managing finances, dangerous to self or others, or exhibiting behavior that brings them into conflict with the community. Services may be provided with or without consent, if guardianship is required. Such agencies may facilitate hospitalization or assist with various legal actions
Community care	
Respite care	Respite care is provided on a short-term basis (usually several hours to several weeks) to a dependent person in the community to relieve the caregiver. It includes five major categories: (1) In-home, e.g., home companions, homemakers; (2) In-the-community, e.g., adult day care; (3) Institutions caring for elderly individuals, e.g., adult homes, overnight stays; (4) Hospitals; (5) Combination models. Religious organizations, nursing homes, home healthcare agencies, and voluntary agencies commonly organize these services
In-home healthcare services	A wide array of services that can be grouped under three categories: (1) Intensive or skilled services, e.g., wound care, catheters, tube feedings ordered by a physician and under the supervision of a nurse; (2) Personal care or intermediate services for medically stable individuals who require assistance with activities of daily living; (3) Homemaker, chore, or basic services such as light housekeeping or meal preparation to persons with difficulties caring for their themselves, but who are able to do more basic activities of daily living such as feeding or toileting
Related in-home services	There are a variety of services for homebound elderly individuals that can complement or substitute for the in-home services described above. These may be offered by senior centers or other agencies and may include friendly visiting, telephone reassurance, emergency response systems, and chore services
Adult day care	Designed for at-risk persons who are mentally, physically, or socially impaired and who need day services to maintain or improve their level of functioning so that they can remain in or return to their own home. Such programs may also provide some respite for families. They were traditionally categorized into two broad types: health-oriented and social services-oriented; however, affiliations are important. Auspice Model 1: health-oriented programs that include outpatient day centers affiliated with nursing homes and rehabilitation centers that cater to physically dependent, older populations (e.g., nursing, health assessments, social services, and physical, occupational, and speech therapies). Auspice Model 2: situated in an outpatient unit of a general hospital, social service, or housing agency. Most patients are younger than those in Model 1 and can perform activities of daily living; more than 40% have mental disorders, and services are more social and supportive (e.g., case management, professional counseling, transportation, nutrition, education, health assessment). Auspice Model 3: special purpose centers that serve a single type of clientele such as blind or mentally ill persons, those with dementia, or veterans

(continued)

Table 39.2 (continued)

Mutual aid (self-help) groups	Self-help or mutual help groups are one of the most popular network modalities. Self-help groups have several key attributes: (1) They are composed of members who share a common condition, situation, heritage, symptoms, or experience; (2) They are largely self-giving and emphasize self-reliance; (3) They offer fact-to-face fellowship network, available, and accessible without charge; (4) They tend to be self-supporting rather than dependent on external funding. Examples include informational and emotional support groups, such as Alzheimer's caregivers groups, and political action groups, such as the Gray Panthers. Self-help groups have been organized with the financial assistance of churches, community organizations, and community mental health centers
Nutritional services	
Home delivery program ("Meals on Wheels")	Nonprofit agencies or congregate meals programs prepare, package, and deliver midday meals and occasionally cold suppers or snacks to homebound (according to accepted medical criteria) persons of any age
Congregate meals program	All persons ages 60 and older are eligible to receive inexpensive meals at nearby centers such as churches, senior centers, and schools
"Brown bag" program	Various community groups provide volunteers who fill shopping bags for low-income elderly individuals
Transportation and escort	
Transportation services	Federally subsidized funding for transport (e.g., subsidized taxis, minibuses, and private cars) to assist with physician visits and errands
Escort services	Community agencies and police provide escorts to assist frail elderly individuals with errands and other activities
Shopping assistance	Senior centers and other senior organizations provide transport service to help elderly persons get to shopping centers
Volunteer and employment programs	
Retired Seniors Volunteer Program	Volunteers ages 60 or older work in hospitals, nursing homes, and senior centers
Foster grandparents	Provides a small stipend to low-income individuals age 60 or older to work with youths in need of supportive and affectionate adults; the program is conducted in schools, care centers, and hospitals
Senior companions	Provides a stipend for low-income persons age 60 or over to visit other elderly individuals in nursing homes, hospitals, and private homes
Service Corps of Retired Executives	Gives retired professionals an opportunity to assist small business owners who lack funds to pay for such services
Green Thumb	Requires participants to be age 55 or older and have an income that is below 125% of the federal poverty line; the program employs retired farmers and other rural elders to work part-time in parks and other beautification programs
Senior aides	Offers small stipends for part-time work in community service jobs as homemakers, home health aides, and food program assistants
General community programs	
Adult education	Increasing numbers of elderly individuals are enrolling in tuition-waiver programs in colleges, adult education courses, and elder hostel programs
Senior centers	Participation in senior centers is appreciably greater than any other community-based service for elders. One model views the center as an informal social club or voluntary organization. The other model depicts the center as a multipurpose service provider or social services agency designed to meet a range of needs of frail elderly individuals, particularly poor and disengaged persons
Community housing	
Long-term care	
Nursing homes	These institutions can be divided into two broad categories: (1) Skilled nursing facilities, which provide 24-h nursing care and medical coverage for persons who require extensive care (reimbursement is provided by Medicaid and time-limited coverage by Medicare); (2) Intermediate care facilities that provide health-related care for persons who are more stabilized but require some medical and nursing supervision (not full time); costs are covered by Medicaid but at a reduced level for Medicare

(continued)

Table 39.2 (continued)

Hospice	Provides a setting of comfort and relief from pain in a person's last weeks of a terminal illness. Hospices may be found as a hospital unit, a freestanding facility, an outpatient unit for counseling and medical visits, or a home care program
Board and care homes and residential care facilities (RCFs)	Both of these are generic terms that describe various types of housing with supportive long-term services exclusive of licensed nursing homes. They provide more support to residents than congregate housing or rooming houses. Homes typically provide three meals a day, laundry service, and 24-h supervision; many also provide transportation services, cleaning of living areas, personal assistance, and arrangement of medical appointments. Traditionally, board and care homes and RCFs have fallen into one of three basic types: (1) Homes serving residents with mental retardation or developmental disabilities; (2) Homes serving residents with mental illness; (3) Homes serving a mixed population of physically frail elderly, cognitive impaired elderly, and persons with mental health problems. Most facilities are in the latter category
Assisted living	Assisted living constitutes a new name for a rapidly expanding sector of the traditional board and care housing and RCF sector. These facilities are designed to accommodate frail elderly residents who can live independently but need assistance with activities of daily living
Congregate housing	Consists of apartment houses or group accommodations that provide limited health services and other support services (e.g., meals in a central dining room, heavy housekeeping, social services, recreational activities) to functionally impaired older persons who do not need routine nursing care. These facilities are somewhat less institutionalized than board and care residences
Foster care	For older persons (particularly those with chronic mental illness) in need of care and protection in a substitute family; it provides socialization, stimulation, support, and protection. The number of paying residents is usually limited to four
Single Room Occupancy (SRO) type housing for older people	SRO type housing has been used to house specific target populations such as mentally ill persons or substance abusers. Such units often provide on-site staffing and support
Elder Cottage Housing Opportunity	Also known as granny flats, accessory housing, and second-unit ordinances, these are ancillary structures for elderly persons that are permitted by special zoning variances to be placed on land belonging to the children of these individuals, thereby enabling the older person to receive informal care and support from his or her kin
Continuing care and life-care facilities	These facilities offer multiple levels of care ranging in setting from one's own home to a nursing home. They provide private living units with ancillary services such as meals and health care. When there is a need for more intensive care, the resident may be transferred to a nursing home, often on the same site
Retirement communities	These are nonlicensed, age-segregated communities of apartments or freestanding homes. Services are generally of a social nature (e.g., clubhouses, tennis courts) and do not routinely include health services
Elderly apartment complexes	These include public, nonprofit, and privately owned buildings for elderly individuals, many of which have been built with Section 202 federal funds. They do not routinely provide health care, although they are required to provide a daily meal and to make available housekeeping, transportation, personal care, and chore services
Shared housing ("senior matching")	A social services agency matches occupant (owner/renter) with renter, or the agency buys or rents units and then rents these units to others
Natural Occurring Retirement Communities (NORCs)	NORCs refer to buildings, apartment complexes, or neighborhoods that were not originally developed for older persons and where the majority of residents have become elderly. The term has evolved to mean any building or neighborhood where more than half of the residents are over 60. Innovative programs for these older persons have been established that provide social services, case management, nursing, recreation, and educational enrichment
Geriatric mental health services	
Mental health crisis intervention services	The aim of these services is to provide rapid restabilization of a person's psychiatric symptoms and social adjustment. Crisis services are often hospital-based or tied to community mental health centers. Services may be delivered in the patient's home or at a designated place outside the home. Mobile units or home treatment teams may visit the home or maintain daily telephone contact

(continued)

Table 39.2 (continued)

Community outreach	These programs involve a team of outreach workers and been successful in meeting the mental health needs of traditionally underserved and disadvantaged populations, such as rural elderly individuals, homeless elderly individuals, elderly persons in public housing, or mentally ill older adults in suburban communities
Psychiatric vocational rehabilitation	Although these programs underserve older patients, such programs should be considered as a treatment option for aging psychiatric patients. Two basic types of programs exist: (1) Sheltered employment, also known as sheltered workshops or compensated work therapy programs, provides work opportunities for individuals who are not ready for competitive employment; (2) Transitional employment provides real-work jobs with commercial establishments that are supervised by psychiatric or rehabilitation professionals
Geriatric psychiatry clinics & dementia centers	This programs typically offer multidisciplinary, comprehensive evaluations and care for older adults. They are usually situated at large medical centers
Model programs	As described in Table 39.3, the programs focus primarily on enhancing interdisciplinary collaboration and/or use case managers with clinical skills to provide guidance and counseling to older clients as well to promote appropriate care by primary care providers and interdisciplinary communication

are the predominant site of care for most problems that are psychological in nature (e.g., anxiety, depression), that consumers are more satisfied when their physical and mental health care are integrated in the primary healthcare setting, and primary health care is a better fit with the typical way a majority of consumers present their undifferentiated mental health problems. With this better fit, there may be better treatment adherence and better health outcomes. However, the range of mental health needs that appear in primary care settings exceeds the capacity and skills of even well-trained primary care physicians, although referral to an outside mental health professional is considered a poor alternative. Consequently, programs that create collaboration between primary care providers and mental health professionals may improve the skills of primary care providers in dealing with the psychosocial aspects of care.

There is evidence indicating that these innovative programs can save money. For example, the average cost of the Improving Mood–Promoting Access to Collaborative Treatment (IMPACT) program (see Table 39.3) is approximately $580 per participant. This is modest compared to the high annual healthcare costs (approximately $8,000) in depressed older adults. The cost of providing IMPACT care as a benefit to an insured population of older adults is less than $1.00 per member per month. Gilbody et al. (2006) found that on 4-year follow-up, the IMPACT patients' medical care costs were $3,300 less than patients receiving usual care, even when the cost of IMPACT care is included. This suggests that an initial investment in enhanced depression care not only improves health, it can actually reduce total healthcare costs over 4 years. Despite this and other similar examples of potential cost savings, the innovative programs described below are not typically reimbursed through traditional insurance mechanisms, and may require waivers from Medicare or Medicaid.

In Table 39.3 we describe several large-scale projects that are serving as exemplars for future work.

Primary Prevention

Although the principal focus of this chapter is on secondary prevention (i.e., early detection and intervention of disease) and tertiary prevention (i.e., minimizing effects of disease and disability), community mental health providers are often involved in developing primary prevention programs (i.e., prevention of disease occurrence). Table 39.4 lists some of the techniques suggested

Table 39.3 Model programs for older adults in the community

Program	Study sample	Intervention	Outcomes
Helping Older People Experience Success (HOPES) (Mueser et al. 2010)	183 Persons aged 50 and over with serious mental illness (56% schizophrenia, 24% depression, 20% bipolar) in Boston and New Hampshire	It included a social rehabilitation component and a health management component delivered over a 2-year period. The first intensive year included weekly skills classes, twice monthly community practice trips, and monthly 1:1 meetings with a nurse. The second maintenance year included monthly skills classes, community practice trips, and meetings with a nurse. The health management component is delivered by registered nurses and entails an initial medical history and evaluation of healthcare needs, including preventive health care. The nurses and participants collaboratively set health-related goals for obtaining recommended preventive care and for managing medical conditions	Participants improved more in social skills, community functioning, negative symptoms, self-efficacy, and leisure and recreation than the control group ("treatment as usual"). The improved social skill of the HOPES participants and the greater reduction in negative symptoms are consistent with a smaller trial of social skills training with older persons with psychosis (Patterson et al. 2003). Similarly, improved leisure functioning is consistent with a prior study evaluating combined social skills training and cognitive restructuring in middle-aged– older adults (Granholm et al. 2005). The findings confirmed that psychosocial rehabilitation can benefit older adults with SMI who have longstanding impairments in community functioning. It was comparable to the impact of social skills training on functioning for younger people with schizophrenia and other psychosocial treatments for schizophrenia mainly evaluated with younger individuals, including cognitive remediation
The Mobile Interprofessional Coaching Team (MICT) (Horgan et al. 2009b)	Providers in Ontario, Canada from across disciplines (medicine, nursing, social work), organizations (family health teams, Specialty geriatric mental health outreach, Alzheimer Society, First Link Project) and sectors (mental health, primary care, community and education) to advance a common vision, language, and approach to the diagnosis, treatment, and referral of older adults with complex mental and physical health needs	MICT is founded upon four fundamental concepts (interprofessional practice and education, shared care, knowledge transfer and exchange, and ecological change theory) which together form a foundational approach for building sustainable field-based interprofessional/ intersectoral knowledge exchange. The objectives of the initiative involve: (1) Creating effective collaborative processes for postlicensure professionals across healthcare sectors; (2) Building the capacity (i.e., knowledge, skills, experience) of postlicensure professionals to engage in and benefit from effective interactions with providers in other key disciplines and sectors; (3) Fostering role and responsibility sharing between disciplines, organizations, and sectors; (4) Enhancing access to pertinent materials (tool kits, fact sheets, articles, question and answer forums, etc.) relevant to the care of older adults with complex mental health needs	A variety of knowledge transfer strategies have been implemented which involve cross-disciplinary and cross-sector representation including: collaborative practice coaching sessions; collaborative educational sessions; and interprofessional preceptorships. These activities are indirectly supported by an information management and knowledge exchange repository

The Program to Encourage Active and Rewarding Lives for Seniors (PEARLS) (Ciechanowski et al. 2004)	138 Patients aged 60 years or older with minor depression (51.4%) or dysthymia (48.6%). Patients had a mean of 4.6 chronic medical conditions; 42% of the sample belonged to a racial/ethnic minority, and 72% lived alone	A home-based program to manage depression that was conducted in collaboration with various community agencies working with older adults. Intervention participants were scheduled to receive PST by PEARLS therapists. Therapists used a PST treatment manual. PST is a skills-enhancing behavioral depression treatment based on the assumption that problems of daily life cause and maintain depressive symptoms, and through systematically identifying and addressing these problems, patients can achieve decreased depressive symptoms. A psychiatrist also reviewed medical problems and medications for all patients, and sometimes clarifying details by contacting primary care physicians and/or contacting patients. The availability of such telephone contacts with physicians or patients optimized patient safety and increased the comprehensiveness of the intervention	At 12 months, compared with the usual care group, patients receiving the PEARLS intervention were more likely to have at least a 50% reduction in depressive symptoms (43% vs. 15%), to achieve complete remission from depression (36% vs. 12%), and to have greater health-related quality-of-life improvements in functioning and emotional well-being
The Improving Mood–Promoting Access to Collaborative Treatment (IMPACT) (Unützer et al. 2002)	Persons aged 60 years or older with major depression (17%), dysthymic disorder (30%), or both (53%) from 18 clinics in 5 states. Patients were randomly assigned to the IMPACT intervention ($n=906$) or to usual care ($n=895$)	An example of primary care, clinic-based depression care management. Intervention patients had access for up to 12 months to a depression care manager who was supervised by a psychiatrist and a primary care expert, and who offered education, care management, and support of antidepressant management that was provided by the patient's primary care physician and/or a brief psychotherapy for depression provided by the care manager, viz., Problem-Solving Treatment in Primary Care	At 12 months, 45% of intervention patients had a 50% or greater reduction in depressive symptoms from baseline compared with 19% of usual care participants. Intervention patients also experienced greater rates of depression treatment, more satisfaction with depression care, lower depression severity, and less functional impairment, and greater quality of life than participants assigned to the usual care group. The authors concluded that the IMPACT collaborative care model appears to be feasible and significantly more effective than usual care for depression in a wide range of primary care practices

(continued)

Table 39.3 (continued)

Program	Study sample	Intervention	Outcomes
Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) (Bruce et al. 2004)	Randomized controlled trial with patient recruitment (aged 60 and over) from 20 primary care practices in New York City, Philadelphia, and Pittsburgh regions. 276 Screened for depressive symptoms or depression history in the intervention group and 266 in the control group	Tested the impact of a primary care-based intervention on reducing major risk factors for suicide in late life. The intervention consisted of treatment guidelines tailored for the elderly with care management compared with usual care. The PROSPECT intervention focused on two major components of care: (1) Physician knowledge, addressed by a clinical algorithm for treating geriatric depression in a primary care setting; (2) Treatment management, operationalized by depression care managers. The algorithm recommended a trial of an antidepressant. If a patient declined medication, the physician could recommend interpersonal psychotherapy from the care manager. Care managers collaborated with physicians by helping them recognize depression, offering guideline-based treatment recommendations, monitoring clinical status, and providing appropriate follow-up. They had psychiatric backup. The care manager interacted with patients in person or by telephone	Rates of suicidal ideation and the resolution of suicidal ideation declined significantly faster in intervention patients compared with usual care patients. Intervention patients had a more favorable course of depression in both degree and speed of symptom reduction. The intervention's effectiveness in reducing suicidal ideation, regardless of depression severity, reinforces its role as a prevention strategy to reduce risk factors for suicide in late life
Supportive Intervention for Depressive Symptoms in Caregivers of Patients with Alzheimer's Disease (Mittelman et al. 2004)	Participants were 406 spouse caregivers of Alzheimer's disease patients who lived at home at baseline. The caregivers were randomly assigned to either a group receiving enhanced counseling and support treatment or a group receiving usual care (control group)	The first component consisted six counseling sessions, individual and or group. The content of these sessions was determined by the needs of each caregiver. Counselors also provided education about Alzheimer's disease and community resources. The second component of the intervention was participation in a support group, beginning after the first component. The third component of the treatment was the continuous availability of counselors to caregivers and families to help them deal with crises and the changing nature of the illness	After baseline differences were controlled for, caregivers in the enhanced treatment group had significantly fewer depressive symptoms after the intervention than did the control subjects. These effects were sustained for 3.1 years after baseline, similar across gender and patient severity level, and sustained after nursing home placement or death of the patient

Table 39.4 Primary prevention of mental illness in older adults

Intervention terminology	Approach	Target	Objectives	Examples
Universal prevention	Population	Entire population, not identified based on individual risk	Implement broadly directed initiatives to prevent substance misuse, mental illness and suicide-related morbidity and mortality through reducing risk and enhancing protective factors	Physical and mental health screening, health education, exercise
Selective prevention	Population; high risk	Asymptomatic or presymptomatic individuals or subgroups with risk factors for substance misuse, mental illness, or suicide; or individuals who have a higher-than-average risk of developing substance use or mental disorders; bereavement; poststroke patients	Prevent morbidity and mortality through addressing specific characteristics that place older adults at risk	Physician advice and warnings, medication reviews, patient education, gatekeepers, caregiver support groups
Indicated prevention	High risk	Individuals with detectable symptoms and/or other primary risk factors for substance abuse, mental illness, or suicide	Treat/intervene with older individuals with precursor signs and symptoms to prevent development of disorders or the expression of suicidal behavior	Problem-solving, caregiver counseling, depression management, provider collaboration, CBT or IPT for depressive symptoms

Adapted from Blow et al. (2005)

for aging populations. The literature suggests that one of the key modalities to prevent psychiatric disorders in older adults is for primary care providers to identify and recognize persons who are at-risk for more serious psychopathology. With respect to depressive symptoms, it may mean using a simple screen such as the 2-item Prime-MD (e.g., "Do you feel sad?" "Have you lost interest in doing things?"), and if these items are positive, then probe further, especially for any suicidal ideation.

Those interventions that have shown promise in the prevention of depressive or reduction of depressive and anxiety symptoms include exercise, education (e.g., mind–body wellness courses; health education), problem-solving therapy, support for caregivers of dementia patients, and use of gatekeepers for more at-risk individuals.

For substance abuse problems, screening tools such as the CAGE (Ewing 1984) may be used to identify possible alcohol problems and reviewing computerized prescription information can identify misuse of prescribed medications. With respect to prevention, patient and provider education programs about parameters regarding use of alcohol in aging adults and the appropriate use of prescription medications, especially in combination, have been shown to be potentially useful.

Evidence for prevention of dementia is limited, but there is some evidence that low socioeconomic status in early life, lower education, physical cognitively stimulating activities, higher quality of social networks, and lowering vascular risk factors such as hypertension, diabetes, smoking, hyperlipidemia, and Mediterranean-style diets may be useful, especially if initiated in middle life (Polidori et al. 2010).

Blazer et al. (2009) suggest that clinicians can also affect primary prevention of mental disorders by identifying potentially stressful elements in the older adult's environment, both physical and social. They give examples of addressing social isolation caused by a medical illness, misuse of medications, working with the bereaved, or identifying metabolic conditions that might contribute to impaired cognition such as low vitamin B12 levels or thyroid disease.

Guiding Principles of Geriatric Care for "Ideal" Individual Program and Service Systems

Dening (2008) lists seven principles that the World Health Organization has identified as essential to providing high quality care to older adults with psychiatric disorders. These underlying principles can serve as a scaffolding of values for geriatric psychiatry programs and provides an ideal to which all program may strive. They form the acronym CARITAS:

A *comprehensive* service that takes into account all aspects of a patient's physical, psychological, and social needs

An *accessible* service with respect to geography, culture, finances, and language

A *responsive* service that acts quickly to address problems

An *individualized* service that is tailored to each person and his or her environmental context

A *transdisciplinary* approach that involves the collaboration and contributions of various service providers

An *accountable* service that accepts responsibility for the quality of care

A *systemic* approach that integrates all available services

In addition to envisioning an ideal individual care geriatric program it is important to consider the components of the ideal comprehensive service system for older adults. Lebowitz (2006) suggests that the ideal system must contain community-based services such as activity centers, day care, home health care, and respite care; institutional care in the hospital and long-term care; aggressive outreach, comprehensive assessment, and vigorous case management. He observes that such a comprehensive and rationally designed system does not exist in the United States. Rather, a patchwork of fragmented and uncoordinated services has evolved in most communities. Not surprisingly, various reports have historically characterized older adults as underserved, inappropriately served, or not served with respect to psychiatric care.

The anticipated dramatic growth in the psychiatric needs of older persons in this country in tandem with their increased numbers of older adults in the general population is creating an emerging crisis. Consequently, community psychiatrists will increasingly be called upon to provide care and develop treatment programs for older adults. This chapter provides a toolkit for community practitioners to work with older adults—the basic principles of geropsychiatry, the key community resources, innovative models of care—as well as an understanding of some of the important broader systems issues, particularly preventive strategies.

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Rural Populations

40

Paulette Marie Gillig, Ann K. Morrison, and Helene Silverblatt

Introduction: What Is Rural?

Rural populations are diverse, but some generalizations can be made (U.S. Congress 2002; Economic Research Service, U.S. Department of Agriculture 2005). With few exceptions, there are proportionally more poor people in rural areas than in urban areas. Rural people are three times more likely to live in substandard housing than people who live in more urbanized areas (Post 2002). People in rural areas have poorer physical health. Rural residents have a lower median educational attainment and are less likely to be in white-collar occupations. More than 25% of rural workers earn less than the federal poverty rate. Often they have no health insurance.

One challenge common to rural areas is that people are less likely to seek treatment for mental health issues, until they are very ill.

> Ms. A is a 45-year-old woman who is brought to the emergency department by her sister who was summoned back to the remote area by a neighbor of their deceased mother when Ms. A. appeared on the neighbor's doorstep, after living in an outbuilding of their mother's property. Her deteriorating "nerve" condition had gone undetected for several months, as her adult children had moved from the area the year before to find work. Ms. A was first hospitalized in another county (as there was no facility in her county) for stabilization with antipsychotic and antidepressant medications. Prior to discharge, the Assertive Community Treatment team contacted Ms A's parents' old friends for local social support and temporary housing. The team recognized that this housing hinged on a tenuous system that could not function very long. They worked with Ms. A on independent skill development while she stayed with friends and began the lengthy process for obtaining housing subsidy because they knew that low income housing stock was short in the area and the family home was now in foreclosure.

Rural Culture and Economies

Rural culture is changing. The number of people living on farms in the United States is at an all-time low, due in a large part to the failure of small family farms. Ninety-seven percent of men and 100% of women admit to depression associated with farm failure (Belyea and Lobao 1990; Conger and Elder 1994; Gunderson et al. 1993) and about one half of men and one third of women

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admit to becoming more physically aggressive (Hanson 2000). Due to economic conditions and the inroad of industry and factories in farm areas, women have now entered the work force to support failing family farms. This has created role strain as the man (and often the woman) attempts to maintain the image of the man as the "breadwinner," even though it is the woman who actually is financially supporting the family (Weigel and Baker 2002).

Psychiatric Epidemiology and Service Response

Arguably, these changes in rural culture have contributed to an increased prevalence of certain psychiatric disorders, particularly depression and chemical dependency. They have also taken a toll on the children's mental health.

Depression and Suicide

There is significant depression and a higher suicide rate in rural communities than in urban communities, especially among elderly males and Native Americans (New Freedom Commission 2004; Goldsmith et al. 2002; Wagenfeld et al. 1994; Eberhardt et al. 2001; Fiske et al. 2006). The suicide rate for elderly is possibly related to the availability of firearms (Rost et al. 1998). Iowa and North Dakota have developed programs to serve the homebound rural elderly, including geropsychiatric social work teams. Service needs are assessed at on-site screenings at community settings such as supermarkets, schools, senior centers, and other sites. Referrals sometimes are made by other social service agencies or informal "gatekeepers" such as the mail carrier, veterinarian, or utility workers (Letvak 2002).

Of the 88 counties in Ohio, the two most rural counties are, on a per capita basis, ranked second and sixth in suicide (Ohio Department of Development: 2005 Ohio County Profiles. Researchand Data Office of Strategic Research, http://www.odod.state.oh.us/research). In Iowa, the suicide rate in 2008 for rural counties was 13.55 per 100,000 persons vs. 11.46 in urban counties (Harris 2010). Forty one percent of rural women report depressive symptoms (Hauenstein and Boyd 1994; Probst et al. 2005), as compared to a typical urban prevalence rate of 13–20%. Higher rates of depressive symptoms were found in rural West Virginia as compared to the nation as a whole (Muntaner and Barnett 2000). Age, unemployment status, and lack of education were associated with more depressive symptoms.

Depression also may be more intractable to treatment in rural settings. Adams et al. (2006) found that a "depression disease management" program improved the mental health status of urban patients over 18 months but not rural patients, independent of medication or specialty care counseling. In addition, depressed rural patients were hospitalized more than their urban counterparts, with greater length of stay. The reasons for these differences are not entirely clear.

> Ms. H reports that she has been having a lot of difficulty in recent months because her "nerves have been acting up." She endorses loss of appetite for 1 month, insomnia for at least 2 months, and difficulty engaging in her usual activities (weekly breakfasts with female friends, church, and bowling). She offers a number of somatic complaints including gurgling, upset stomach, feeling fatigued, shortness of breath, constipation, and exacerbation of shoulder and wrist pain for which she has been to her family doctor about 3–4 times in the last few months. She denies feeling depressed saying she has "too much work to do to be depressed."

It is quite common in rural populations for benzodiazepines to be prescribed because patients complain primarily of "nerves." This patient also complained of musculoskeletal pain and one would want to inquire about the use of narcotic analgesics. People expect to have problems with their "nerves," which they view as an issue for primary care, or else experience somatic symptoms that they do not connect with mental disorders.

Substance Use Disorders

The presentation of mental health disorders as "nerves" or other somatic symptoms such as pain leads to treatment with benzodiazepines and narcotic analgesics such as oxycontin,

"hillbilly heroin," or illicit use of these drugs and is one factor in the comorbidity of substance use disorders and mental illness in rural areas. Alcohol, methamphetamine, and over-the-counter medications are also commonly abused. The production of some substances such as cannabis and methamphetamine has become part of the local economy, hampering efforts to convince patients to view their own involvement with substances as aberrant. Fewer programs that exclusively treat substance abuse are located in rural areas (Gillig et al. 2002), as substance abuse treatment is usually delivered along with mental health treatment there. Substance abuse previously had been found to be more common in rural Native American youth than in rural White youth, as was the comorbidity of substance abuse and psychiatric disorders (Costello et al. 1997). Recently, there have been more positive findings in outcomes of substance abuse treatment among Native Americans with 6-month remission rates for alcoholism of 41% (Gilder et al. 2008). Some rural areas have adopted more formal integration of services with Integrated Dual Disorder Treatment (IDDT) teams with success (Mclean 2010, Personal communication; Kruszynski 2010, Personal communication). They note interest in web-based treatment of substance use disorders.

A web-based alcohol treatment program has been developed targeting rural women who might have even greater problems accessing standard treatment due to family responsibilities, lack of transportation, or high stigmatization with alcoholism. The program had satisfaction scores equal to standard treatment (Finfgeld-Connett 2009). The use of the web for other more informal support via chat-lines also seems to be spreading in rural areas where traditional 12-step groups may be less accessible. Setting up sober support in less conventional and nonagency based, but more convenient, locations such as community rooms in town halls and libraries maybe helpful. The lack of sober social support and leisure alternatives which buttress recovery is a challenge in rural areas and is described in detail by Draus and Carlson (2009).

Child and Adolescent Disorders

The most common psychiatric disorders reported in rural youth are anxiety disorders, enuresis, tic disorders, and hyperactivity. Rural teenagers drink more alcohol and have a higher rate of risky sexual behavior than urban teens (Nordal et al. 2003). Poverty is the strongest demographic correlate to the presence of any of these disorders (Costello et al. 1997).

A 1997 study of farm laborers found that less than half of the rural children who were found to have psychiatric diagnoses had ever seen any health professional for these mental health problems. Using the 2001 National Health Interview Survey, Moore et al. (2005) found nearly 25% of rural children had a potential mental health problem, but less than 20% of these children's parents had seen or talked to a mental health professional about the child in past 12 months. Two thirds of the children involved were living in a Health Professional Shortage Area (HPSA) mental health designated shortage area. Mental health crisis services for children and adolescents in rural settings often revolve around family conflicts and issues with stepparents, situational distress, and abuse of over-the-counter and prescription drugs (Gillig 2004).

The state of Virginia had developed specialized mental health services for Virginia rural youth as ordered by the Virginia Comprehensive Services Act (Sheldon-Keller et al. 1996). Interagency teams were created within one structure, and each rural community had flexibility in designing its system. The team included representatives from the school system, social services agency, community services board, court service unit, health programs, and a parent representative, and funding streams were combined to reduce bureaucratic complexity. School-based clinics improve access for children and adolescents (Welsh et al. 2003) when mental health programs are integrated into these services.

Financing Rural Mental Health Systems

Just as poverty has affected the prevalence of mental health disorders, it has also inhibited capacity to deliver services. Over 85% of the

1,669 federally designated mental health HPSAs are rural (Bird et al. 2001). Of the 55% of counties in America with no psychiatrists, psychologists, or social workers, all are rural. Because rural communities have suffered greatly during economic shifts of the past half century, for example with failed farms and loss of local industry, the tax base has diminished, forcing severe prioritization of local public services. This has been very detrimental to rural public behavioral healthcare programming. And unlike the current planning in place for general rural healthcare (e.g., community and migrant health clinic programs, critical access hospitals), few specific federal strategies for a rural mental health infrastructure exist at this time. Most recently, some state and federal programs and resources have been developed to try to make rural mental health services more affordable to these communities. Owing to the peril of cuts in available state funding, these resources include only a few academic/state/rural partnerships in psychiatry and primary care. There are also limited home and community-based health services waivers from Medicaid; outreach grants from the Office of Rural Health Policy/Health Resources and Services Administration (HRSA); rural interdisciplinary training grants, area health education centers funded by HRSA as part of the Area Health Education Centers Program (AHEC), that link the academic resources of a University Health Science Center with local planning and educational and clinical resources in underserved areas; children's mental health grants for in-home services; and some federal and state grants for school-based health clinics.

Important Models for Rural Mental Healthcare Delivery

University-Sponsored Models

The West Virginia University Telehealth Education Network

Important potential roles for telepsychiatry (described in Chap. 11) in rural settings include audio-video communication between providers, professional training (continuing education), peer support for rural professional practitioners, and provision of specialist support (Wagnild et al. 2006). Nelson and Bui (2010) have described the utility of audio-video psychology consultation and treatment for serving children, adolescents, and families living in rural areas.

University of California at Davis Integrated Program

The University of California at Davis has created an integrated program of mental health screening, on-site therapy, and telepsychiatric consultation to rural primary care (Bird et al. 1998; Lambert et al. 2001; Smalley et al. 2010). According to their website (www.ucdmc.ucdavis.edu>Psychiatry and Behavioral Sciences), the University of California health system collaborates with a community health network in a program for rural Northeastern California, which is funded by grants from private and semipublic foundations. Over a 3-year period, screening instruments and outcome measures were incorporated into the practice at multiple rural sites (e.g., for depression, alcoholism, and anxiety disorders). Telepsychiatric consultations were made available and were integrated into the psychiatry department's consultation-liaison service. Continuing medical education credits have been provided annually for family practice physicians and other providers. Primary care providers eventually were encouraged to shift the method of consultation from time-consuming and costly videoconferencing when possible, to secure email and telephone consultation. Consultation requests from primary care providers to the psychiatry department have reportedly increased over time.

University of New Mexico

The University of New Mexico Department of Psychiatry developed The Center for Rural and Community Behavioral Health in 1993 to provide "community oriented services to underserved populations, engage in rural mental health training and workforce development, and to strengthen the behavioral health services research capacity in New Mexico." The center trains child psychiatry fellows and adult psychiatry residents and serves

as a training, recruitment, and retention tool for rural New Mexico. Two to four adult psychiatry residents per year choose to join the rural psychiatry track. They work 1–2 days each month from 6 months to a year in a rural site during their fourth year. They will have already the opportunity in their third year to visit sites around the state on a monthly basis, eventually using the time to establish relationships within chosen sites and communities. The sites have included community mental health centers, federally qualified health centers, Indian Health Service or tribal facilities, private rural psychiatry practices, and schools.

Child psychiatry fellows work 2 days per month in a rural community clinic or school during their last year of training. Working in schools can take place in school-based health centers and may include consultation with the all school staff, from teachers to janitors to guards to dieticians. Addiction psychiatry fellows have worked with other psychiatrists and primary care providers, providing consultation, training, and service. They have been particularly helpful in consultations with primary care providers in prescribing buprenorphine and naltrexone and teaching about cooccurring disorders that present in primary care environments. Geriatric psychiatry fellows have also provided direct service as well as subspecialty consultation to primary care providers in clinics and nursing homes. Many of these rotations include opportunity to work in clinics and schools through well-supervised telehealth experiences.

Currently, rural psychiatry residents rotate together with family practice, pediatrics, and obstetrics-gynecology residents and dental interns in so-called community training sites. Psychiatry residents provide "curbside consults" to their nonpsychiatric colleagues in these clinics and often see patients together. Funding for the rural track comes through a contract with the state of New Mexico's Behavioral Health Services Division.

Another successful state-funded project at the University of New Mexico includes a multiprofessional team of several disciplines: psychiatry, family medicine, pharmacy, neurology, nursing, and dental medicine, which travels around the state offering consultation for adults with developmental disabilities. This team works actively with rural and community-based referring psychiatrists, primary care providers, speech and language pathologists, occupational therapists, and behavioral therapists, providing consultation and support in the community for the developmentally disabled with complex medical, behavioral, and psychiatric problems. Psychiatry residents are welcome members of this team; they experience interprofessional training and learning as they apply to rural communities.

Wright State University, Dayton, OH

The Wright State University Department of Psychiatry conducts a program in rural and underserved psychiatry within its curriculum of Community Psychiatry. In addition to regularly scheduled didactics for all residents, for the last 16 years the Community Psychiatry program has assigned several third-year residents to work 1 day every other week at a rural or otherwise underserved site. The rural program includes on-site supervision by a professor in the Community Psychiatry division, and ongoing clinical research (Dempster and Gillig 2006; Chu and Gillig 2004; Gillig et al. 1998, 2002; Gillig and Barr 1999; Gillig and Comer 2009; Gillig and McQuistion 2006).

Wright State's Boonshoft School of Medicine recently has been ranked fourth in the nation for its "social mission," as measured by the percentage of graduates who practice primary care, work in HPSAs, or are underrepresented minorities (Mullan et al. 2010).

Outreach and Assertive Community Treatment Teams

Assertive community treatment (ACT) services (described in detail in Chap. 24) have a long track record of decreasing the need for hospital care, which is a resource often lacking in rural areas. Therefore, rural ACT teams may be even more necessary there than in urban settings. However, the recommendation that an ACT team has a staff to patient ratio of 10–15:1, serving 50–100 people, poses challenges and opportunities in

rural settings. Rural service areas may not have sufficient numbers of people with the most severe illnesses to develop full teams in a timely manner. Even if the numbers are present, they may live in dispersed areas, making core services such as outreach difficult. Rural ACT teams also are at risk for having a higher proportion of non-reimbursable activity owing to the extra travel involved.

While the traditional ACT team includes a variety of specialized professionals, it does lend itself well to rural settings in the sense that the model also emphasizes team members functioning as generalists within their scope of practice. An ACT team is typically available 24 h a day, 7 days a week, but a 24-h, 7 day per week coverage may be difficult to provide in a rural environment. For example, some team members may live at great distant from the clinical site and patients' homes. Modifications to the traditional ACT model have not been sufficiently evaluated, including a greater use of the telephone for daily and weekly team meetings, greater attention to geography when dividing up daily tasks, less frequent but longer contacts with patients, enlisting on-call cross-coverage by other agency staff, greater attention to cross-training, and professional development of team members to allow broader practice (for instance, training psychiatrists, nurses, and therapists about substance abuse assessment and services, or informing them about vocational issues if a dedicated position cannot be supported or recruited) (McDonel et al. 1997; Meyer and Morrissey 2007; Mohamed et al. 2009; Siskind and Wiley-Exley 2009). Rural ACT recommendations have been modified to have a lower recommended staff to patient ratio of 8:1 and typically serve fewer people, as low as 42–50. In order to provide shift coverage and maintain the low ratio, a minimum of five mental health professionals are needed on each team (Allness and Knoedler 2003). The following case illustrates that intensive services, including ACT and specialized pharmacotherapy, can be provided in rural areas.

> Mr. L, a 30-year-old single male with schizophrenia and cannabis dependence, lives in the eastern part of the county in his mother's home, about 30 miles from the county seat where the ACT office is located. The psychiatrist on the ACT team has been discussing a trial of clozapine, but the patient and his mother have raised concerns that Mr. L may be unable or unwilling to travel for weekly blood draws, as required with this medication. Arrangements are made by the ACT nurse for Mr. L to have his blood drawn at the family doctor's office, at a more manageable distance from his home. Contact with the ACT team also was increased during this time. A team member added a stop to Mr. L's house on his way home the day prior to blood draws. This served as a reminder, but also allowed for encouragement and problem solving, such as when the family car was inoperable.

Conclusion

Rural practice poses challenges; the patients are often more severely ill, come late to treatment, often do not perceive themselves as having a mental disorder, frequently have comorbid substance use disorders, are in poor physical health, are poor and frequently are uninsured; services in rural areas less extensive, further away and some, such as inpatient psychiatric care, residential substance abuse treatment, and housing programs, may be nonexistent; and professional shortages across all disciplines further complicate care. However, good clinical care can be provided by combining proven treatment approaches adapted to local resources (e.g., state-of-art pharmacology, ACT, integrated dual disorders treatment). While professional shortages may hamper the development of specialized programs, they also allow clinicians opportunity for a more varied, interesting, and holistic practice than may be found in some resource-rich settings. Additionally, sometimes innovation and new program development is easier because the existing system involves fewer programs and organizations, making system-wide change easier to implement.

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Part VIII

Making it All Work: Systems and Administration

Transforming Mental Health Systems and Programs

41

Michael F. Hogan

There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions, and lukewarm defenders in those who may do well under the new. This coolness arises partly from fear of the opponents, who have the laws on their side, and partly from the incredulity of men, who do not readily believe in new things until they have had a long experience of them.

(Machiavelli 1513)

Introduction

The final report of The President's New Freedom Commission on Mental Health (NFC; New Freedom Commission 2003) used the term "transformation" regarding changes needed in mental health care. Since the report was completed, "transformation" has become the buzzword for change in mental health. But having a new label does not make fundamental change any easier, and a new term for change says little about how to actually achieve change in mental health services and systems. How to achieve change for the better remains a vexing problem for advocates and for anyone who accepts responsibility in a mental health program or system.

In this chapter, I use the process by which the NFC did its work to illustrate some guidelines for the process of change in mental health programs and systems. The work of a presidential commission is scarcely a typical example of a mental health leadership challenge or management problem (after all, there have been only two presidential mental health commissions in the USA). On the other hand, short-term task forces, special committees and work groups happen all the time at every level of the mental health system—both within organizations and across them. Any professional or advocate interested in change is likely to participate in such an effort, and many of us will lead one. Examining the processes, successes and limitations of the NFC's work offers a framework for short-term change efforts. It may also illuminate the challenges of ongoing leadership in mental health organizations and systems. The chapter also uses some findings from the Innovation Diffusion and Adoption Research Project—IDARP (Panzano and Roth 2006; Panzano et al. 2007). This was a multiyear study of change in mental health organizations—specifically the factors associated with success in launching and successfully completing a change (the adoption of one or more evidence-based practices) in community mental health agencies. And finally, some lessons from general management and group dynamics are included to help provide guidance for change efforts.

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A Framework for Leading Change: First, Identify Changes That Should Be Made That Can Be Made

Anyone leading a change effort must wrestle with the tension between what should be done and what can be done. Our positive instincts and much of the management literature challenge us to aim high; in discussing successful companies Collins and Porras (1994) cite the importance of Big, Hairy, Audacious Goals (BHAG's). But aiming high in improving mental health care does not guarantee success. Indeed, the history of mental health reform in the USA is that lofty aims are often defeated. Political scientists Marmor and Gill (1989) pointed out that the demands of good care for people with mental illness and the realities of the American political system clash in a way that suggests that truly successful reforms are unlikely in this country. Good mental health care requires coordination and integration of services, demanding a shared approach across levels of government (federal, state, local) and across areas of governmental responsibility (e.g., mental health and health care, housing, income support policies). Yet the nature of American democracy, with its focus on balanced powers and divided responsibilities, mitigates against strong action—especially on behalf of a politically weak minority such as people with mental illness.

Some of the more notable efforts to reform/transform mental health care in America illustrate this problem. Dorothea Dix championed construction of asylums for people with mental illness in the nineteenth century, winning passage of legislation establishing a national construction program for state asylums in 1854. However, President Franklin Pierce vetoed the bill as an unwarranted exercise of federal powers, setting a lukewarm tone for federal leadership on mental health that has persisted until the present. Reforms that followed were often limited or compromised. For example, the Community Mental Health Centers (CMHC) program proposed by President Kennedy sought to establish local community centers across the country. But the CMHC program was only partially and weakly implemented, and bypassed the state agencies responsible for mental health care. Centers that received funding were given 7 year start-up grants rather than ongoing support, and by the time the program was converted to a block grant to the states in 1981, only a fraction of the needed centers had been established. Another example is seen in the 1980 Mental Health Systems Act. This legislation seemed an exception; it provided national leadership to improve mental health care based on strong recommendations of President Carter's Mental Health Commission. However, the legislation lasted only about a year; it was eviscerated in President Reagan's first budget. The balance of powers inherent in American democracy makes changing mental health care—at the federal, state, or local level—a challenging proposition. In this context, finding a balance between what *should be done* and what *can be done* is a particularly important consideration in changing mental health services. President Bush made this balance explicit for the NFC, saying in his speech announcing the effort "the commission will make recommendations *that can be implemented*, *and they will be implemented*".

Selecting a target for change that is significant yet feasible is essential. The first part of this "change equation" goes to the heart of leadership: *what is it that should be done*. In the case of the NFC—as in many cases of organizational change—the broad direction of change was prescribed. A higher authority may mandate that something is addressed. An incident may reveal a quality of care problem that must be corrected. But even in these situations, the target of change must be selected—and choosing this goal or guiding its choice is delicate and important.

In clinical care, an assessment and diagnosis suggests what the treatment must be. As the Institute of Medicine noted in defining evidence-based practice (2001), treatments should be consistent with the best current research on care for a condition, acceptable to the patient/consumer, and shaped by the practitioner's skills and training. Is this framework relevant for

choosing the direction of change for "organizational practitioners?"

I believe the answer is affirmative, suggesting that choosing a direction for change in organizations is as critical a decision as choosing the right treatment in clinical care. Change for a mental health organization must move the organization in a valued direction, consistent with the evidence about the prevalence and distribution of need, and those interventions that are effective. Certainly, there are alternative directions that are often suggested: the way we used to do things, the approach that is easiest or offers the path of least resistance. But the task of leadership is to frame a direction that is *right* in terms of current knowledge and our best values. One aspect of leadership responsibility is to consider emerging scientific knowledge. For example, there is substantial new knowledge of the effectiveness of targeted preventive interventions, especially for children (O'Connell et al. 2009). Leaders should use this knowledge to shape approaches to care.

The other considerations in the IOM's definition of evidence-based practice are also relevant to organizational change. Just as a treatment must be acceptable to an individual—considering personal preferences and cultural norms, the direction of change in an organization must be acceptable to the organization itself (for example the staff and board) and also to key players in the environment (funders, partners, advocates). Launching a program that is desirable but which no one will pay for is scarcely a wise decision. And, just as treatments must be delivered in a fashion consistent with a clinician's skill set and training, the changes taken on by an organization must be feasible for that organization in terms of capabilities.

Similar factors were crucial in the decision making process studied by the IDARP researchers (whether or not to adopt an evidence-based practice). Significant decisions in an organization are characterized as "risky business"; leaders must weigh the value of change to their organization and assess whether it can be successfully implemented. The study reveals that an organization's capacity for change can be bolstered by experience; earlier successes in making changes increase an organization's willingness to try, and ability to make changes (Panzano and Roth 2006). The study also indicates that an organization's capacity and willingness to make change can be increased via actions that leaders can take: creating an environment conducive to learning, promoting a positive management attitude toward change, and dedicating resources to the change process. These findings illustrate a central facet of change—leadership is central, and what leaders do or do not do makes a difference.

The challenge of proactive leadership is not simply to dictate a direction for change that "works" in the mind of the person in charge. Defining a direction—such as launching a course of treatment—involves a dialogue and collaborative process with the participants. The leader must have a good idea about the general direction but must also orchestrate the change process to bring people along, expand their vision of what is acceptable, and build capabilities and confidence to make the change. Some of the tactics used during the NFC process may be relevant to shaping and sizing the direction of change in local or statewide efforts.

Engage Shareholders in Return for Their Support

In the case of the NFC this meant meeting individually as well as collectively with all the major national mental health advocacy organizations. Eager for input, they agreed to work together to submit ideas for consideration, and generally pledged their support. The support of these organizations and the general lack of contentiousness that resulted created a "safe space" for the NFC to do its work, while informing the commission about considerations that would make recommendations more acceptable. Dialogue with shareholders is an essential step while launching a change effort. Often, mental health constituents are as concerned about whether they are consulted as they are about many details of change.

Engage Legislators and Policy Makers in Advance of the Recommendations

The key officials to engage depend on the context of the change effort you are involved in (e.g., local or statewide, internal to an agency or public). With the NFC, engagement meant a round of meetings with senior federal officials in the participating agencies and with members and senior staffers of Congress. In this process, the limits of influence were painfully clear. While involved White House staff and leadership in the Substance Abuse and Mental Health Services Administration (SAMHSA) were very supportive, there was no mandate to other federal agencies to commit to policy change, and support from the different agencies varied. And the general reaction from Congress—aside from some activist leaders—was "This is an initiative of the Administration. We will wait and see if it amounts to anything. If it does, they will make recommendations and we will decide. Meanwhile we're working on *our* agenda." Though these strategies had limited effectiveness for the NFC, it was a time-limited effort. Gaining buy-in is even more essential in a change effort where preparation must lead to action.

Managing the Change Process: Timing, Process, and Organization

Timing is everything in change. Just as in a game of chess, every change scenario has a beginning, middle and end. Different tactics must be employed in the different stages of change and different success factors are involved in each. In the beginning, the leader must set the direction, develop expectations and boundaries, and create a management process to get the work done. In the middle of a change process, the work must be carried out while unanticipated issues are dealt with—without losing focus or momentum. In the end game, the transition to the implementation phase must be planned and executed, and an orderly ending to the change process itself achieved and celebrated.

The Beginning or Opening Phase of a Change Process

In the beginning stage, as in the opening of a chess game, the possibilities are wide open. Based on a strategy and direction, the leader makes the initial moves that establish a strong position while expending the minimum necessary resources. An example from the NFC process was using time in the very first commission meeting to focus on the recently completed Surgeon General's report (1999) via a presentation by Howard Goldman MD, senior scientific editor of the report. This presentation, at a time in the process when members were eager to become a working group and get started on their task, led to a quick agreement to use the Surgeon General's report as a foundation. This was an efficient way to establish the right direction, and conserved energy that might have been wasted in reviewing countless other issues and reports rather than moving forward. Participants in a change process are often quite willing to reasonably defer to the leader on many issues at the beginning, and taking advantage of this while launching change is essential.

A key activity in the early stage of any change effort is to develop a clear plan and approach to get the work done. For example, the NFC established subcommittees to work on topics/issue areas. The subcommittees provided a framework that was used to set deadlines and accountability for key tasks. Since every appointed NFC member chaired or co-chaired a subcommittee, it gave them ownership of the subcommittee work. Securing resources to do the work of change—which may involve tasks outside of an organization's normal day-to-day activities—is also essential. For example, appointed members of the NFC were generally local mental health practitioners, advocates and administrators rather than national "policy wonks." Therefore, consultants with a national perspective on each subcommittee's topic were provided to advise members and provide an initial policy analysis for consideration.

A final essential element of any change process is to establish boundaries or norms for participation. In the case of the NFC, this was addressed via informal group meals to develop camaraderie, and briefings by White House and other federal officials that clarified the need to work together—following the rules. Individual calls with each of the appointed commission members before the first meeting helped establish a group identity and create "buy in."

The Middle Game

In chess, the major considerations for the middle game are to enhance your position while preserving resources. Similarly, in a change process effort you must get the work done, manage resources and deal with issues that emerge. Key issues in the middle of the NFC process were to maintain a very active liaison with constituencies, keep work going on 15 subcommittees and deliver an *Interim Report* (New Freedom Commission 2002) on time. The Interim Report, with its stark and candid assessment that "the system is a shambles" communicated to stakeholders that the NFC's view of the system would be unsparing. It raised expectations for the final report and thus strengthened receptivity to the commission's message.

Unexpected issues will arise in any change process. In the case of the NFC, adjustments included dealing with clinical and policy issues (e.g., the role of technology, the significance of trauma) that had not been anticipated at the beginning when the subcommittees were created. The middle part of a change process within an agency or system—as opposed to a task force or commission—may be even more complex: timelines or commitment to the change effort may be threatened by the press of ongoing challenges. Assuring that there are adequate resources to manage the change process is essential. The management structure for a presidential commission includes an Executive (staff) Director appointed by the White House and a small staff. The commission is housed in a sponsoring agency. In the case of the NFC, SAMSHA Administrator Charles Curie created an additional position of Deputy Executive Director and recruited a long time colleague who was a strong manager of details. Additionally, he provided a budget for consultative and logistical support. Inevitably, a change process will include twists, turns, and demands that raise resource questions. Managing these is essential for the process to succeed.

The End Game

Obviously one core challenge for the end stage of a change process—as in the game of chess—is achieving closure, whether this means agreement on a plan or recommendations, or completing a report. This task may be made more difficult (as in the case of the NFC) because participants have bonded and want to continue their work—even if the time has come to end the process. This dilemma—the result of normal group dynamics that I discuss later—can lead to conflict over recommendations that is due less to substantive disagreement and more to the fact that agreement means the end of the process. Another challenge in any change process is to manage the transition from planning change to implementing it. This was a group process challenge for the NFC because the commission was explicitly time limited and had no role in implementation. But it also meant the end of the work was the end of the effort.

Learning from other change efforts can help in planning the end game. A lesson for the NFC leadership was that work products from the Carter mental health commission subsequently catalyzed change, sometimes in a fashion that went beyond formal recommendations. Koyanagi and Goldman (1991) described how issues discussed during the Carter commission were carried on by federal staff and advocates, finding their way into the government's National Plan for the Chronically Mentally Ill. Implementation of these actions led to many incremental but significant changes in policy, even during the Reagan administration. The NFC tactic of multiple subcommittees, each staffed by a consultant was also an attempt to emulate this success. We

hoped that candid subcommittee reports not subject to the federal "clearance" process could become part of a national advocacy strategy. This was only a partial success. For reasons that are still not clear, only five of the 15 subcommittee reports were published by SAMHSA. On the other hand, the consultants who had advised the subcommittees retained intellectual property rights to their initial reports. Many were edited and submitted to the journal *Psychiatric Services* and published independently as policy papers—e.g., Cook (2006) and O'Hara (2007). This kept the recommendations alive in the mental health community.

Another tactic in wrapping up the planning phase of change is to ensure that recommendations have a "home" in an entity that can carry out implementation. In the case of the NFC, the Center for Mental Health Services (CMHS) in SAMHSA was charged with coordinating implementation activities and development of an "Action Agenda" for change. In their study of implementation success, Panzano et al. (2007) found a range of factors that contributed to success across the whole implementation period. These included consistent top management support (balanced by freedom in the organization to express doubts), availability of technical assistance when needed, and dedicated resources—to assist with implementation and to monitor its effectiveness. In the end stages of planning a change, these issues must be considered in the transition to implementation.

Group Process as a Vehicle and Metaphor of Change

Mental health services and the mental health system—like human groups and organizations generally—are complex, "open systems." The behavior of complex systems is unpredictable and counterintuitive. Actions that appear strong may fail because they lead to strong resistance (e.g., passage of the Mental Health Systems Act), while apparently "weak" actions can lead to substantial change…*if* they are the right actions at the right time in the right place (Senge 2006).

While the complexity of human systems and attempting to change them is daunting, mental health leaders interested in change are perhaps better prepared than many realize. This is because group work is a common element in mental health treatment, and the fundamentals of group dynamics are perhaps the core competencies of change. Interactions in groups (work groups, committees, task forces) are a dominant part of organizational life and the heart of any change process. We must bring the skills of group leadership to the challenges of leading change. While a broad review of group dynamics is beyond the scope of this chapter, illustrating several fundamental elements of task group behavior will demonstrate the centrality of group leadership skills in the change process.

Students of group behavior know that some of the most important initial work on the behavior of groups working on a task was conducted by Wilfrid Bion, a psychoanalyst. Bion's observations of group dynamics were based on observation and experience with psychotherapy groups. Nonetheless, his observations are deeply relevant to all human groups including leadership teams and corporate boards. Bion (1948) concluded that human groups can only be understood if one appreciates that there are really two groups functioning at the same time. The portion of the group's energy devoted to the work he described as the task group, while other group energies form the "basic assumption group." This portion of any group's activities may be devoted, for example, to *dependency* ("who's in charge here, why are we meeting?") or *fight–flight* (e.g., the group delays beginning its work, or refuses to come to closure because doing so might end the work and thus the group's existence).

Bion's observations are fully in play in any change process that involves groups, committees or meetings—in short in any change process. The most obvious—yet often ignored—implication is that leaders must pay attention to the unconscious and emotional side of groups if they are to function effectively. Efforts to build friendship, trust, and working relationships pay off in productivity and the quality of the work. While the NFC's

leadership used a number of conscious efforts to build group identity, an unscripted example from the process of the NFC illustrates the byplay between the emotional side of a group's work and the task side. The example has to do with how the term "transformation" became the consensual rallying cry of the commission.

Surrounded by flip charts in a long and exhausting meeting near the end of the NFC's work the discussion turned to how to frame or label the changes that the group was calling for. It was an exhausting discussion. The term "reform" seemed old and tired. State level change efforts have used terms such as California's "realignment," but these did not resonate deeply. Many ideas were raised and abandoned. The group was tired. After a long discussion, in a moment of pregnant silence, SAMHSA Administrator Charley Curie—interestingly, the only social worker member of the commission, asked "what about *transforming* the system?" The Commission decided on "transformation" as a descriptor of change by acclimation.

How does this story serve as an example of change and of understanding group dynamics? The choice of "transformation" as a theme by the Commission members was a classic example of group decision making and of leadership. For various reasons, Charley Curie wanted to use the term "transformation" in the report. We are often in this position; wanting to get our key idea included in a decision. How does one know how to achieve this? The story offers a good example. Solutions offered early in a decision process will often be passed over, often for reasons that illustrate Bion's distinction between "task" and "basic assumption" dynamics. A group that has not "formed" (either early in a process, or early in a specific meeting) is unlikely to evaluate a suggestion based on its merits. Even if the conversation seems like a rational evaluation of the proposal, what may be going on is likely an unconscious exercise in group formation. The effective leader will help the group form a healthy identity, providing an opportunity for everyone to be heard/feel a part of the process. (I am constantly surprised how much the simple step at the beginning of a group process, of asking people to share who they are, and what they bring to/expect from the work, helps to normalize group behavior.) Also, because of the basic assumption dynamics present in every group, suggestions made by the leader are especially significant. Suggestions made by formal leaders early in the process will often be adopted—or rejected—based on a seemingly superficial discussion. The underlying issue is not the content of the proposal but a group formation problem. So leaders must be careful about their role in introducing content. In the case of the NFC, Curie played a very low-key role as an equal member of the group rather than as the administrator of the lead federal agency (SAMHSA). This, ironically, made his role as a commission member more effective.

The other lesson in this little episode has to do with timing. In a group process, since emotional/basic assumption forces are often dominant, when ideas or solutions are introduced has a lot to do with how the group receives them. It is said that Henry Kissinger was a master negotiator and that one of his tactics was to hold very long negotiating sessions with plenty of water on the table—which he would not drink. Somehow, ideas offered near the end of a meeting are more likely to be accepted simply because the group is ready to end/move on. Kissinger's ploy simply strengthened the impulse. Curie's timing illustrated how an idea offered at the right time is likely to be accepted. So the NFC chose the term "transformation" in part because it was right, but in part because it was offered at the right time in the right way by a leader—who happens to have had plenty of experience running treatment groups! Leaders must be aware of both the basic assumption and task aspects of group process, and address both to achieve good decisions that are well accepted.

Update: Action on the NFC's Recommendations

Having focused on the process of the commission, it is reasonable to ask what progress has been made in implementing its recommendations—although less than a decade has passed.

The record is mixed. The mandate of the commission as defined in the President's executive order was focused as much on motivating the field as on policy recommendations ("the Commission shall…formulate policy options that could be implemented by public and private providers, and by Federal, State and local governments…"). Leadership responsibility for coordinating federal follow-through fell to the CMHS, which convened federal agency staff to develop an "Action Agenda" focused on implementation activities.

From afar, it appears that CMHS is simply "buried" too far within SAMHSA (itself a relatively modest sized agency within the Department of Health and Human Services) to exert policy level influence. The most potent activity carried out by CMHS was to initiate a new series of major grants to selected states, using a grant mechanism (State Incentive Grant-SIG) that had not been previously used by CMHS. The T-SIG (Transformation State Incentive Grant) grants provided several million dollars annually over a 5 year period to selected states through each state's Governor's office, and focused on an array of activities motivated by the commission's report. Seven state grants were awarded in the initial cycle and two more grants followed in a second cycle. No comprehensive evaluation of this effort has been published; however, it appears that federal grants are not a potent way to change state systems. Following the initial round of T-SIG awards, the CMHS grant effort was repackaged from major state grants to more focused, smaller grants. Dozens have been awarded and implemented.

From afar, it appeared that the robust role played by SAMHSA Administrator Curie waned after HHS Secretary Tommy Thompson left the Bush Administration, and was replaced by former Utah Governor Mike Leavitt. Activity motivated by the commission's report by the participating federal agencies was uneven. The Veteran's Administration, already dealing with the mental health consequences of the Iraq War, used the commission report to advance a recovery agenda (e.g., hiring consumer peer advocates in its hospitals). But federal action to advance the recommendations during the rest of the Bush Administration was uneven. And, although the Obama Administration has seemingly placed a higher emphasis on mental health issues, political tradition does not favor relying on—or perhaps even mentioning—initiatives of a previous administration.

The major impact of the commission's activities in the few years since appears to have been in local communities and programs where the themes of recovery, and of change which can be "bottom up" as well as "top down," have resonated with many in the field. There is no way to accurately measure this impact, although a Google search for "mental health transformation" yielded 3.3 million results. Only time will allow an adequate assessment of the commission's impact, and it will probably never be possible to assess whether change that occurred was due in any way to its work. The fact that its work proceeded without major conflict of controversy and that the reports were generally well received is about all the evidence we have of effectiveness at this time.

Conclusion

Leading change in mental health services and systems is a paradox. On the one hand, every change process is unique to a particular time, place, and culture. On the other hand, there are patterns which can be learned and approaches that can be mastered to greatly increase the chances of success. This chapter reviews some principles of change. A crucial initial factor is choosing change targets and goals that are both relevant and achievable.

Timing is a crucial variable in any change process. Actions to be taken at the beginning, in the middle and near the end of a change process must fit the stage of change; each phase presents distinct challenges and opportunities. Finally, group processes are at the heart of every organization and change effort. This is a comforting realization for mental health professionals who usually have training in group work. With attention and practice, the techniques in group

leadership can be applied to work groups and change processes. Research on change in mental health agencies—specifically on the adoption of evidence-based practices by community programs—is also comforting. Many factors determined to influence the success of change are common sense.

"Transformation" has become more popular as a term for change since the NFC used the term in its 2003 report. It is probably appropriate as a label for change, since it implies both substantial change—surely needed in mental health—and an approach that is not necessarily top-down or structural. Transformative change affects not just process or structure, but alters how things are done. Like the process of recovery from mental illness, transformative change is a journey, and a process that alters the nature of things. By approaching the task of change armed with knowledge and tools, we can accelerate it and achieve more lasting results.

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42 Exercising Effective Leadership

Jacqueline Maus Feldman

Introduction

In order to exercise effective leadership in community psychiatry, one must be and do a variety of things: enjoy interfacing with people, be motivated and passionate about working in systems of care; be creative and innovative; be ready and willing to be an advocate for one's self, one's staff, and one's patients in terms of providing quality care; practice a specific skills set; be willing to undergo training in a wide variety of topics; and be open to receiving, and changing from feedback. This chapter reviews the extant literature which describes the desired attributes of an effective leader, suggests venues of training necessary to support skills acquisition, and identifies system of care requirements to facilitate growth in leaders who understand and embrace community-based recovery-oriented systems of care.

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Why Do We Need Psychiatry Leadership in Community Mental Health?

With the move towards de-institutionalization in the mid-1960s, massive numbers of patients were discharged to the community where they continued to need mental health follow-up. A system of care consisting of networks of community mental health centers (CMHCs) rapidly grew, requiring new leaders to direct clinical care, to plan community supports, and to advocate for a vulnerable population. Training mental health leaders became a high priority to the US federal government from 1977 to 1984. The government empowered and funded the National Institute of Mental Health Staff College to promulgate the goals of the CMHC Act of 1963. The Advanced Training Program in Mental Health Administration for cohorts of CMHC directors was developed. It included ten 4-day retreats with pre- and postactivities and provided training for hundreds of people (Mazade 2006).

Unfortunately, since that time, coordinated, recovery-based organized training has not occurred on a consistent national level. The number of psychiatrists in America has remained stagnant, although the number of psychologists has doubled and the number of social workers has increased by 20%. Funding for mental health

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training fell from $117 million in 1972 to less than $1 million recently. Bottom line: a serious gap in leadership training has occurred (Mazade 2005). And then, in 2007, the Annapolis Coalition released *An Action Plan for Behavioral Health Workforce Development*, assessing American behavioral health care workforce needs, and making recommendations for change. The Coalition targeted training the next generation of mental health leaders as imperative, particularly underscoring the need for leadership in order to respond to the national embrace of rehabilitation and recovery-oriented philosophies. Interestingly, the Coalition recommended training the entire behavioral health workforce, *including*

> persons in recovery and families, educators, prevention specialists, treatment providers, policy makers, and the individuals who manage accreditation, certification, and licensure systems. In fact, developing and expanding a cadre of leaders among persons in recovery, youth, and family members is particularly critical in achieving transformation of current service systems and models of care. Leadership must be broadly defined to encompass not only organizational and change management, but also coalition and community building, team and program management, and the provision of supervision (Annapolis Coalition, 2007, p. 19).

Studies have shown that the number of psychiatrists is woefully inadequate for the present mental health demands in America. Konrad et al. (2009) reported that the United States is about 45,000 psychiatrists short of the necessary number to treat a population with a 4% incidence of mental illness. It is probable the demands for care will only grow. "The global burden of disease attributable to mental, neurological, and substance use disorders is expected to rise from 12.3% in 2000 to 14.7% in 2020" (Murray and Lopez 1997, p. 1498). There are increasing numbers of patients moving from institutions (state hospitals, jails and prisons) to the community. There continue to be chronically high numbers of patients with serious mental illness (schizophrenia, bipolar disorder, major depression) whose lives can be very challenging and whose care is complex and demanding. There are patients with distressing and disabling mental health problems (anxiety, personality disorders, substance dependence) who are unable to access private health care because of their location, finances, or insurance status but since they need care, they often seek it in emergency rooms or local hospitals. It is anticipated the 2010 passage of The Patient Accountability and Affordable Care Act will promulgate extensive health care reform, with the numbers of Medicaid eligible patients dramatically increasing by 16–23 million, with 11–17 million people presently uninsured having access to insurance, and ostensible ability to demand service (Kaiser Family Foundation Report 2011). Without leadership in community psychiatry, planning of systems of care might fall to others who do not carry the educational background, motivation, or commitment to the concepts of inclusion, evidence-based practice, harm-reduction, and recovery as community psychiatrists. There are countless past examples of poorly planned care systems that have rushed to cut costs or restrict care, with terrible results. Community psychiatrists must be prepared to step up to leadership roles.

The Annapolis Coalition has created an action plan on the development of Behavioral Health Workforce (2007) noting a variety of factors that exponentially contribute to increasing burden on mental health care providers: an insufficient workforce to meet demand, increasingly more complex patient populations including those with co-occurring disorders (mental illness/substance abuse/medical problems), those released from the criminal justice system as it attempts to downsize, shifts toward recovery models of care, increased use of medications (thus requiring skilled and knowledgeable professionals), a push for "best practices and evidence based interventions," demands for service outside routine mental health venues, patient outcome/performance improvement standards, and stigma (Annapolis Coalition 2007; Hoge and Morris 2002, 2004; Hoge et al. 2005). Anthony and Huckshorn (2008) believe mental health leaders must step up to meet the need of systems of care that are becoming increasingly committed to the rehabilitation/recovery paradigm and new organizational

structures and financial schemes that are responsive to pressure for inclusion of consumers and standards of outcome accountability, including scrutiny from a variety of sources (executive, legislative, media, citizen boards, advocates, and the judiciary).

What Is Leadership?

When considering generic leadership (meaning that which is not specifically tied to mental health care), Burns (1978, p. 2) wrote, "leadership is one of the most observed and least understood phenomena on earth." Leadership has been defined in many ways, some by attributes of the leader, some by the goals or products that leadership should produce, some by the followers, and some by the environment in which they exist. Gardner (1995, p. 1) defines leadership as "the process of persuasion or example by which an individual (or leadership team) induces a group to pursue objectives held by the leader or shared by the leader and his or her followers." Gardner notes, "Effective leadership is a combination of a particular context and the attributes needed to lead in that context" (1995, p. 39). Leaders in these situations need to inspire commitment and action, lead as peer problem solvers, building broad based involvement, and sustaining hope and participation. They should "convene, energize, facilitate, and sustain this process" (Chriship and Larson 1994, p. 146). Collins (2006) has written regarding effective leadership in the nonprofit sector, noting that this sector often struggles with a diffuse power structure, and that successful nonprofit leaders recognize the need for legislative skills (persuasion/motivation) to influence not only their direct subordinates but also a wide variety of constituencies. Nonprofit organizations move from good to great by (1) measuring success not necessarily in the money that is made, but the resources they can expand, (2) employing passionate workers who "are down to earth, pragmatic, and committed to excellence" (p. 10), and (3) recruiting leaders who have "humility, defined as burning ambition, transferred into the cause, with brutal, stoic will" (p. 8).

Specific to mental health, William Anthony prefaced the superb book *Principled Leadership in Mental Health Systems and Programs* (Anthony and Huckshorn 2008, p. 1) with this statement: "Leadership remains an art as well as a science—some of the tools of leadership are not simply the tools of science—some are tools of the self." He also noted, "…leadership creates a shared vision and mobilizes others toward specific organizational goals consistent with that vision" (2008, p. 11).

Personal Attributes and Skills of Effective Leaders

Van Wart (2005) believes the leader should have integrity, self-discipline, passion, and self-confidence. Upon interviewing business leaders at their major corporations, Martin (2005) also includes as coveted leadership attributes of patience, confidence, decisiveness, and optimism. Rowitz (2001, pp. 23–24) has identified that a more nuanced skills set leaders should develop: knowledge synthesis; creativity; vision and charisma ("able to create a vision and get others to share the vision and demonstrate a commitment to the vision and the mission it represents"), facility in collaboration as seen in forming coalitions and building teams; entrepreneurship; understanding of the "strategic interdependencies" of systems; and an ability to set priorities and translate innovative ideas into practice. The leader is never just an individual who leads in a vacuum, but one who is constantly scanning the environment for opportunities to engage, connect, coach, teach, and experiment, pulling on their abilities to "construct a learning environment…and to promote reflection, conceptualization, and thinking." They seize on times to inspire, and connect, translating different meanings and wishes of disparate constituencies.

The capacity to form effective decision-making groups is also imperative in leadership. Bens (2006) focuses on the values embraced by leaders whose leadership role he believes includes being a facilitator, and notes that facilitator leaders "offer process and structure rather than directions and answers. In every situation, they know

how to design discussions that enable group members to find their own answers" (Bens 2006, p. 93). These facilitator leaders believe that:

- People are intelligent and capable, and they want to do the right thing.
- Everyone's opinion has value, regardless of an individual's rank or position.
- Groups can make better decisions than individuals acting alone.
- People are more committed to the ideas and plans that they create.
- People will take responsibility and assume accountability for their actions and can become partners in the enterprise.
- The role of the leader is to evoke the best possible performance from each member of the team (Bens 2006, pp. 8–9).

The guiding principles of *each* action are (1) empowerment, (2) collaboration, (3) creativity (Bens 2006, pp. 41–42).

More specific to mental health care, Anthony and Huckshorn speak to leadership attributes that move beyond the simple requisite personality traits and more primitive definitions of style. Instead, the focus for mental health leaders should be on actions and principles. They suggest that "mental health leaders universally seem to be characterized by commitment, credibility, and capacity to make change" (2008, p. 224).

Evolution in the Types of Leadership

Leadership in mental health has been in transition for many years, moving from authoritative through transactional to more transformative models (Van Slyke and Alexander 2006). *Transactional* leadership and its evolution to *transformational* leaderships are best described by Burns (1978): transactional leaders work with followers to exchange one thing for another. A transactional leader stresses efficiency, planning and goal setting, focusing on competency, structure, and maintaining the organization. He or she may be more reactive than proactive, and is often supportive of the status quo. The transforming leader, by contrast, looks for what motivates followers, seeks to gratify higher needs, and works to engage the *whole* person of the follower (intellect, energy, passion, values). Transformational leaders move followers into being leaders and may convert leaders into moral agents. They are responsive to others' needs and interests and are responsible and accountable to stakeholders (Alimo-Metcalfe and Alimo-Metcalfe 2006). They seek to engage others by appealing to their higher needs, working for the greater good, and becoming leaders. These leaders focus less on hierarchy and more on relationships, teamwork, and innovation; they display humility, a generous spirit, honesty, and integrity. Transformational leaders have current and future situational awareness, with a vision, believing in proactive change, adaptability, and entrepreneurship. Organizations that are highly transactional are shaped by rules and regulations, rigid structure, contracts and controls, while those that are more transformative are characterized by strong vision and purpose, support change, and have trusting, cooperative interactions between staff and leaders (Alimo-Metcalfe et al. 2007; Bass and Avolo 1993; Bass 1998; Burns 1978).

Others claim that effective leadership requires a balance between transactional and transformative leadership, with effective leaders using both forms of leadership depending on the needs of the situation. Luke (1998, p. 37) has coined the term of this combined approach: "catalytic leaders"; they set the stage, pull people together, decide what to do, make plans, make them happen, and create an effective work culture by balancing a hierarchical approach with an approach that engages and incentivizes.

Effective Leadership

In the literature some authors distinguish between leadership and management. Some believe both are needed if an organization is to prosper. Anthony and Huckshorn (2008) opine that managers solve problems while leaders focus their efforts on building the organization for the future, but do agree that the skill sets are not necessarily

mutually exclusive. For Gardner (1995), leaders are different from managers, as leaders are more likely to think long-term; understand relationships to larger realities, organizations, and other constituencies; and underscore vision, values, and motivations. For Alimo-Metcalfe et al. (2007, p. 5), "a leader motivates and inspires; a manager controls and problem solves. A leader produces change, and a manager produces efficiency." Some consider managers as more transactional in orientation, where leaders are considered transformative. Still others assert that good leaders must also be good managers, and vice versa. "Management is a role which underpins an organization's ability to perform, while leadership is a behavior that breathes life into organizational performance. Together they communicate vision, shape an organization's culture, build a high performing workforce, promote diversity, apply sound management practices and business operations, create networks of external relationships, and apply functional and technical knowledge" (Beinecke 2009, p. 7).

Anthony and Huckshorn interviewed 16 leaders in mental health, summarized these results, recast their questions, and threw a larger net, interviewing 34 other national leaders in mental health. They distilled their responses, and wrote *Principled Leadership* (2008, p. 13) denoting, "the goal of mental health leadership is to increase the probability that people with severe mental illness are helped to recover in a setting and through a process that is both effective and efficient." They derived eight principles with numerous corollaries that spoke to the need to establish meaningful *visions* (what future the organization is trying to create), the *missions* (the role the organization has in creating that future), the *operations* (daily activities to accomplish the mission) and the *values* of the organization (templates that guide the organizational decisions made that direct the daily operations). The following are the eight principles of leadership delineated by Anthony and Huckshorn (2008, pp. 235–239):

- *Principle 1*: Leaders communicate a shared vision.
- *Principle 2*: Leaders centralize by mission and decentralize by operations.
- *Principle 3*: Leaders create an organizational culture that identifies and tries to live by key values.
- *Principle 4*: Leaders create an organizational structure and culture that empowers their employees and them.
- *Principle 5*: Leaders ensure that staff is trained in a human technology that can translate vision into reality.
- *Principle 6*: Leaders relate constructively to employees.
- *Principle 7*: Leaders access and use information to make change a constant ingredient of their organization.
- *Principle 8*: Leaders build their organization around exemplary performers.

Based on combined years of leaderships in community psychiatry, the American Association of Community Psychiatrists (AACP) (http://www.communitypsychiatry.org/default.aspx) has promulgated principles and standards for systems of care to enhance and sustain quality of services while ensuring that psychiatric leadership has sufficient supports to maintain these standards (AACP 1995). An abridged summary of the roles and duties of a medical director for a community behavioral health organization is as follows:

1. All organized mental health service delivery systems should identify one psychiatrist as the Medical Director and ensure that that individual has adequate salaried time to perform his/her administrative responsibilities, and to ensure adequate supervision of psychiatric services in order to maintain high standards of care in all system components.
2. Each program within an organized delivery system must have one physician identified to provide medical/clinical direction for that program, with the amount of time allocated for that function to be commensurate with the size and complexity of clinical need of that program.
3. The Medical Director shall have ultimate clinical authority, but must function primarily as a collaborator and team member, both with the administration and with clinicians of other disciplines, in order to be maximally effective

in accomplishing the goals and functions of the position.

4. The Medical Director shall be delegated ultimate authority and responsibility for ensuring psychiatric oversight in all clinical activities.
5. The Medical Director shall be delegated the ultimate authority and responsibility for ensuring psychiatric involvement and/or oversight in the following administrative areas: job descriptions for system psychiatrists; criteria for adequate psychiatric staffing within the system; recruitment and supervision of psychiatrists; staff training; quality assurance, CQI, risk management, and outcome evaluation; utilization review; policies regarding medical and psychiatric evaluation; treatment protocols; medical records/documentation standards; and involvement in program budgeting, program planning, and program development.

A model job description for the system medical director is also available on the AACP Web site. Further elaboration on the job of a medical director is also found in Chap. 44 on the role of the medical director.

Necessary Training to Become an Effective Leader

Establishing core competencies sets the stage for training of leaders. A review by Kanji and Mouraesa (2001, p. 703) describes these core competencies for leadership excellence as leaders who are trained in: "ethics and principles; communication; customer orientation; organizational change; structures and systems; measurement, evaluation, and reporting; process improvement; team development; developing subordinates; developing partnerships; and innovation and continuous learning." Specific to public health (compared to "just" business leadership) Koh and McCormack (2006, p. 17) outlined competencies of public health leadership, which was also called the "servant model":

1. The ability to acknowledge the unfamiliar and the ambiguous
2. The ability to cultivate the higher value of interdependence
3. The ability to recognize crisis leadership as an evolving part of public health
4. An understanding of the "public" part of public health leadership
5. Sensitivity to and respect for the community
6. The capacity to nurture the spirit
7. The ability to hone succinct and concrete communication

Some say that great leaders are born, not made; others suggest that one can learn by observing and working with an effective leader, and still others encourage those seeking to enhance their skills sets or to achieve certain competencies to receive training. This chapter addresses the latter two. Reading *Principled Leadership* and other noted references, one can begin to hear the voice of an effective leader. DVDs, podcasts, conferences, webinars, one-on-one discussions and supervision, and classroom lectures can contribute to one's leadership background information. As importantly, interactions on a day-to-day basis with patients, family members, staff, and systems of care can open one's eyes to the effectiveness of leadership that underscores the importance of embracing a recovery philosophy, as opposed to the unfortunate consequences of uninspired or feckless leadership that ignores the importance of consumer-driven services. An interesting example of an initial treatise on transformative leadership is the AACP Keystones for Collaboration and Leadership (2007) which delineates both a process for transformation of community psychiatry in one state, as well as the issues that must be considered, including transformation to recovery-focused systems of care.

Engaging in a system of care that is going through transformation and observing the effectiveness of thoughtful leadership is one route of training and education. Receiving supervision as one attempts to establish solid leadership techniques is also helpful in supporting skills acquisition and identifying the system of care requirements to facilitate leadership. The National Council for Community Behavioral Health Care has established a 1 year curriculum for physicians in medical/psychiatric leadership positions in community psychiatry whose vision is to "help psychiatric leaders in the community setting

engage better as members of their executive team and to improve the quality of care for patients" (National Council 2011). In addition, the AACP has developed the "Community Psychiatric Practice Mentorship Services," offering a 1-year mentoring by seasoned community psychiatrists to community-based behavioral health organizations who want their physicians to develop their skills in "clinical, administrative, and public policy issues" (AACP 2010).

Other leadership training opportunities have been offered to enhance leadership skills, typically with supportive research findings:

- "The effective teamwork and leadership programme" (Onyett and Borrill 2003) was a 7 day action based program for 21 people funded by the Leadership Centre and rolled out by the CSIP Development Centres, with generally positive evaluations.
- The federal Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored several studies on behavioral health leadership training at the state level. Leadership competencies were summarized in The Transformation Leadership Competencies Wheel (SAMHSA 2005, p. 2; www.samhsa.gov/matrix_mh.aspx).
- The American College of Healthcare Executives (ACHE) offers leadership training on a variety of topics; these include addressing topics in both system and personal leadership competencies. Training then focuses on learning about governance, development of strategies, relationships between physicians, ethics and values, involvement in public health and community, health policy and law, and integrative medicine (www.ache.org).
- NCLH: The basis of much current health leadership training in the United States is the model developed by the National Center for Healthcare Leadership (NCHL 2005; www.nchl.org/ns/documents/CompetencyModel). A benchmarked, researched, and validated model, NCHL takes 26 leadership competencies critical to the field of health and assigns them to one of three domains—Transformation, Execution, and People—that serve to capture the complexity and dynamic quality of the health leader's role.

Additionally, there exist additional too-numerous-to-count online and face-to-face offerings to enhance leadership skills (examples: American College of Mental Health Administration (2006); ATTC Leadership Institute for Addictions Professionals (2005), California Health Care Foundation Leadership Program (2007), California Institute for Mental Health Leadership Institute (2008)). The physician who wishes to enhance his or her competencies will find no short supply; the challenge is finding the venue that is user friendly, effective, and salient to community psychiatry.

Assessment of Leadership Effectiveness

How does one know that effective leadership has indeed ensued? Bass (1998) developed the Multifactor Leadership Questionnaire (MLQ) to measure transformational leadership (inspirational/charismatic, individualized consideration, intellectual stimulation), transactional leadership (contingent reward, management by exception), and laissez faire management, and showed that while every leader typically does some of each, transformational components are correlated with effectiveness, satisfaction, and extra effort in public and private sectors. There are multiple benchmarking tools on the market to assess if leaders are meeting their goals; the Center for Creative Leadership offers a 360° assessment tool for measuring leadership effectiveness and skills (http.www.CCL.com) and the International Initiative for Mental Health Leadership (2011) provides support and technical assistance to participating countries/organization (including SAMHSA) to assess their leadership training (www.iimhl.com).

The AACP has develop a tool (the ROSE: Recovery-Oriented Services Evaluation) which asks clinicians to rate their organization in terms of fidelity to recovery-oriented philosophies. It has 46 questions related to administration (for example: "promotion of recovery is included in the organization's mission and vision"), treatment (for example: "all clinical

services encourage the use of self-management principles"), supports (for example: "choices made by service users are respected by providers"), and organizational culture (for example: "service users feel valued and welcomed"). One rates the organization on each question from zero to three, deriving a final score that then "measures" the recovery orientation of the organization. On face validity, it would appear that the ROSE might be able to identify those organizations still struggling to embrace recovery, although validity and reliability studies of the instrument are not yet available (AACP 2003).

Conclusion: Transforming Leadership in Community Psychiatry

It is critical that community psychiatry leaders step forward to assume leadership positions. With dwindling numbers and increasing demand, processes for planning to respond to new challenges must be put in place by leaders skilled in transformation, who know how to perform strengths-based assessments and elicit consumer-centered treatment planning, and who embrace philosophies of rehabilitation, recovery, and inclusion. The necessary attributes of effective leadership are reviewed. Training and education options are proffered, in the hopes that psychiatrists can be engaged and energized to meaningfully advocate and contribute solutions to this century's new mental health challenges in community psychiatry.

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43 Service and Resource Management*

Wesley E. Sowers

Introduction

In previous chapters of this book, we have considered the evolution of behavioral health services over time, influenced both by ethical/philosophical and economic factors. On the one hand, we agree that service development should be driven by quality concerns and outcomes. More recently, the choices of the people using services have also become an important source of influence. On the other hand, we have had to recognize that there is expense associated with the provision of quality services and that our resources are not unlimited. Over the last three or four decades, the conflict between these opposing concerns has been intensifying, and it would appear that this tug-of-war could continue indefinitely. As the costs of providing care rise and economic conditions deteriorate, these issues become even more prominent. Psychiatrists and other behavioral health practitioners, working primarily in publicly funded programs, find themselves in the middle of these struggles, and thus are obliged to think about how they can use available resources wisely and fairly while maintaining a reasonably high quality of care. It is only through these endeavors that we can efficiently use resources to provide sufficient care to the greatest number of people (Frank and McGuire 2005; Pincus et al. 2007).

In this chapter, we consider the historical context of the tension between service provision and resource use and then examine various approaches to guide service intensity decision-making, or put more simply, how we decide who gets what. We will then consider the elements of rational service-resource management, the goal of which is to maintain a reasonable balance between the two. The final part of the chapter will discuss the Level of Care Utilization System (LOCUS) and its Child and Adolescent counterpart (CALOCUS). These instruments were developed by the AACP to guide and create consistency in service intensity decision-making and to help establish a rational balance between quality care and the efficient use of resources (American Association of Community Psychiatrists 1996).

The Evolution of Resource Allocation

In the past, decisions regarding the location and intensity of treatment were left almost exclusively to the physician. People with severe mental

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illnesses were treated in state hospitals when they were considered to be very ill or in the community with limited professional support when they were considered to be fairly stable. The criteria used to make these decisions were not well defined or consistent, but the doctors' orders were rarely questioned. With a growing sensitivity to civil rights and social justice following World War II, the restrictiveness and frequently poor conditions of state institutions, along with the high cost of maintaining them, resulted in the release of many more people with severe mental illness to the community. The advent of psychotropic medications is also seen as a factor facilitating this shift. Both the community and the patients were ill prepared for this change, however, and as a result, needs of many people were left unmet.

Gradually, public systems began to develop a broader service array, but little thought was given to the costs associated with providing these services by the practitioners who prescribed them (Sharfstein et al. 1993; Boyle and Callahan 1993).

There were several factors that contributed to this lack of awareness. Psychiatric residency training programs rarely made reference to cost issues, and most were situated in resource rich (university) environments. Physicians became accustomed to thinking about benefits relative to risks, but not costs. A good bit of expense can be generated in attempting to maximize benefits when there is limited risk, with very little added benefit. With no limits on what insurers would pay for, "doing more" was hard to resist. Systems (hospitals) did not discourage this perspective, because they too would be paid more if more were done! Professional liability was another part of the equation, fanning the flame of "over" treatment, or what has been called defensive medicine. Even in systems that were publicly funded, providers were generally paid for the services that *they* decided were necessary with very little scrutiny of whether they actually were needed, or effective. More intensive care was often equated with "better" care, although there was no substantial evidence to support this belief, and it often conflicted with the desires of its recipients (Frank et al. 1996; Brosowski 1991; Lesage and Tansella 1993). These factors contributed to the soaring costs of medical care in the latter part of the twentieth century, and to some extent, still do today.

During this same period, technological advances and the growth of expensive pharmacological interventions brought health care to a point where it was becoming prohibitively expensive. Entities paying for health care began to scrutinize the care being prescribed, and to consider ways increase accountability and to control costs. Companies specializing in managing resources quickly sprung up and emerged as the predominant solution to the cost problem. These companies would contract with paying entities to regulate the resources being used for health services. Although they are commonly referred to as managed *care* companies, their real function is to manage *resources* (Roman and Morrison 1997). Their profit and performance, in contrast to providers, is derived from limiting *payment* for services as much as possible. Although they did not make clinical decisions directly, their decisions regarding payment had a direct impact on clinical care. Providers could not afford to provide services that were not paid for (Backlar 1996).

Medical Necessity Criteria

To be successful in containing costs, it was important for resource management companies to determine when and what services were absolutely necessary to adequately treat a defined condition, and which were not. Criteria sets were created, primarily through "expert" consensus, to indicate the conditions for which payment would be provided, and under what circumstances. The development of these medical necessity criteria in behavioral health, as in physical health, arose from the desire to control costs, and to do so, at least on the surface, in a way that was uniform, responsible and driven by outcomes.

The term "medical necessity" originated in the physical health treatment environment and the appropriateness of its application to behavioral health has often been questioned. For physical health problems a specific illness or injury may require a specific type of treatment regimen

to reduce or eliminate their impact and these interventions can be fairly easily quantified and tested for efficacy. This evidence-based approach to designating the need for specific interventions is fairly distinct from what is available in behavioral health. In behavioral health, rather than defining specific interventions or procedures for a condition, medical necessity criteria try to address how to use a spectrum of interventions for a given syndrome and with what intensity they should be applied. The array of services that may be designated for a particular diagnosis is still largely intuitive and based upon an individual's constellation of needs. Even though attempts are made to develop a broader database of outcomes associated with particular types of treatment approaches for given conditions, the complexity of developing a strong evidentiary base is orders of magnitude greater for behavioral health services because of the multiple factors that influence these outcomes (Gregoire 2000).

Despite these limitations, in behavioral health, attempts have been made to codify which clients fit best into existing treatment programs or program "types" as a way to insure that costly services are not used when they are not necessary. The concept of "level of care" envisioned a gradient of service intensities from community based out patient services at the low end, to highly structured hospital based care at the high end. Traditional formulations of medical necessity criteria generally follow a format in which a particular type of treatment program is described, often along with some minimum requirements for staffing and operations. This is usually followed by a diagnostically driven criteria set which defines particular characteristics of persons who are appropriate for admission to the described program, another set describing how one remains eligible for continuing treatment in the program, and a third set describing how a client qualifies for "discharge" from the program.

These attempts at injecting some objectivity into level of care, or service intensity decision-making processes are simplistic, but they are not simple. Providers and service users find them difficult to access and understand. In many cases they are seen as rigid, unclear and not connected to clinical activities such as assessment and treatment planning. In addition, they are inconsistent with person centered (individualized) services. As a result, this approach is increasingly seen as obsolete in the context of our evolving service environment (Goldman et al. 1997).

Instruments for Management of Services and Resources

The emergence of "managed care" companies and of medical necessity criteria in behavioral health had some impact on costs, and particularly on the practice of physicians, who were now compelled to justify their decisions regarding the care they prescribed (Rabinowitz et al. 1995; Frank and Garfield 2007). This arrangement of having an outside entity making decisions about payment was not popular however, and clinicians frequently perceived their decisions as mercenary and clinically insensitive (Jellineck and Nurcombe 1993). One of the difficulties of this system was that there were a multitude of managed care companies, each developing its own distinct set of medical necessity criteria, which were often cumbersome or difficult to access. This made it very difficult to become familiar with any one of them. The use of multiple criteria sets creates inconsistency in clinical thinking, and suggests a lack of integrity and justice in clinical care. Case-by-case scrutiny of clinical decisions by a third party was also a costly process, using resources that would otherwise be available for services (Jellineck and Nurcombe 1993; Sabin 1994).

The challenge then became one of developing systems of management that would enhance the wise use of resources and eliminate the use of unnecessary services while limiting aspects of third party resource management that were costly and disruptive to quality care. To meet this challenge, standardized methods for assessing service needs and an array of services for meeting them, which were broadly agreed upon by all stakeholders, were needed (Glazer and Gray 1996; Uehara et al. 1996). There are several advantages that come from creating a common language and a common methodology for thinking about

clinical needs and resource utilization (American Association of Community Psychiatrists 1996; Nudelman and Andrews 1962). It allows for the development of consistent and rational clinical thinking and provides integrity to service provision (Uehara et al. 2003). Communication is facilitated, and elements of treatment planning are more easily identified and implemented. Finally, when the interests of both cost-efficiency and quality care are considered in the development of standards, the need for oppressive scrutiny of all clinical decisions is eliminated along with the associated expenses (Gibbons et al. 2008). Occasional audits are sufficient to assure that standards are being applied appropriately.

Clinical rating scales had been in use for sometime, developed by clinical researchers to quantify the severity of symptoms or disability in their subjects (Overall and Gorham 1962; McLellan et al. 1980). While these instruments could be used to provide some measure of a persons needs, they were often narrowly focused on particular diagnostic categories or populations. For example, the Multnomah Community Ability Scale (Barker et al. 1994) provided ratings of function in several categories for persons with severe mental illness and was useful in developing treatment plans, but like other similar instruments, it provided no guidance for prescribing services to adequately meet these identified needs (Overall and Gorham 1962; McLellan et al. 1980; Derogatis 1994).

Responding to the need for an instrument linking needs to services, professional organizations, service researchers and resource management companies began to make attempts to do so. The Level of Need-Care Assessment Method (LONCA) used need profiles along with demographic and epidemiologic information to calculate costs and resource use within systems of care, but its complexity limited its usefulness for clinical decisions making (Srebnik et al. 1998; Uehara et al. 1996). The American Society of Addiction Medicine developed the ASAM Patient Placement Criteria for persons with substance use disorders in the 1990s, and it is still widely used today. It uses six dimensions to assess clinical status and to create profiles that are employed to determine service needs. In its most recent iteration, nine levels of service intensity are defined to meet identified needs. It also attempts incorporate mental and physical health issues into the assessment process, broadening the scope of its utility (American Society of Addiction Medicine 1996).

Several other instruments were developed following this basic design; dimensional assessment leading to a needs profile used to determine eligibility for admission, continuing care and discharge for defined levels of care (Glazer and Gray 1996). Some of these developed rating scales for the assessment dimensions that provided a quantitative method for determining eligibility for defined levels of service intensity, making the matching process somewhat simpler (Kazarian and Joseph 1994; Roy-Byrne et al. 1998). The assessment dimensions used by these instruments varied in number and content, but elements such as safety, social and role function, symptom severity, and environment were common to most. A continuum of care with levels of service intensity was generally described, rather than the more specific program related descriptions used in previous iterations of medical necessity criteria. Despite these advances, no single approach emerged that was comprehensive, practical, accessible, integrative, reliable, and broadly accepted (Goldman et al. 1997).

The foregoing account of evolving practices to manage resources and services is brief and simplified, but provides a context for the remainder of this chapter which will consider the development of LOCUS and CALOCUS by the AACP in the middle and late 1990s. The development of these instruments was intended to meet demands for a single standard that would provide practical and rational service level recommendations (Sowers 1998). After more than a decade of use, they have emerged as the leading candidates to meet these demands.

The Design of LOCUS (and CALOCUS)

The design of LOCUS began with a conception of rational care and service management. Many of the elements of this concept have been alluded to earlier:

- Maintains a balance between quality and cost concerns

- Informed by evidence or outcomes
- Operates with a full array or continuum of services
- Allows individualized, person centered service planning
- Uses standards that are broadly acceptable and uniformly applied
- Does not require significant additional time or expense
- Allows integrated management by service providers

A few of these elements require some further elaboration. (1) Most systems will have some gaps in the continuum of services that they can offer, but to manage resources wisely, services that can meet identified needs efficiently are necessary. (2) Individualization means that rather than trying to fit a person's needs into existing services, a unique plan is developed to meet that individual's needs. (3) Management systems should not be expensive and drain valuable resources from service provision. Systems that allow providers to make decisions about both care and resource use, perhaps with some guidance and assumption of risk, are most efficient because they eliminate redundancies and micromanagement, which are costly.

With this concept in mind, the AACP designers attempted to identify principles to guide the development of an instrument that would compliment and facilitate this model of rational management. Ten principles were derived through a review of existing instruments and an amalgam of personal experiences. These principles are summarized below:

1. *Simple*: Instruments should be easily understood and used, requiring little additional time to apply.
2. *Dimensional*: Approach to assessment and criteria development should facilitate consistent clinical thinking.
3. *Concise*: Dimensions should be clearly and succinctly defined, minimizing the number, complexity, and redundancy of factors considered.
4. *Integrative*: Dimensions should be relevant to both substance use disorders and other psychiatric disturbances, and reflect their interaction with physical health
5. *Relevant*: Observable behavior related to symptom severity or functional impairment should be used in dimensional assessments rather than diagnostically based formulations.
6. *Quantifiable*: Dimensional rating scales enhance communicability, interactivity between variables, and reflect the dynamic nature of clinical circumstances over time.
7. *Flexible*: Service continuum definitions should be flexible and adaptable to a variety of systems for broad application.
8. *Person centered*: Defines individual needs that translate easily into service plans.
9. *Empowering*: Allows consumers and their significant others to participate with providers to develop service recommendations.
10. *Reliable and valid*: Level of care recommendations should be made reliably and should provide valid responses to the clinical and social circumstances.

Assessment Dimensions

Building on these principles, the AACP workgroup completed the design of the LOCUS. LOCUS uses six assessment dimensions. One of these dimensions is composed of two subscales, giving a total of seven scales which must be completed. Each of these scales is rated from 1 to 5 with specific criteria for each increment in rating. A composite score is obtained which ranges from 7 to 35 and weighs prominently in the determination of level of care recommendations. The six evaluation dimensions are described briefly below:

1. *Risk of harm*—This rating reflects the degree to which a person is at risk for harming themselves or others. This risk may be due to suicidal or homicidal ideations, or due to impaired judgment or impulse control resulting from intoxication or otherwise altered mental states. Criteria for this rating include factors such as suicidal or homicidal thoughts, intentions, ambivalence, history of attempts, impulsivity, and availability of means. Criteria are also included that indicate the degree to which one's ability to keep themselves safe is impaired.

2. *Functional status*—This rating measures a person's level of function relative to their baseline functional status. The criteria consider the ability to interact with others, to maintain hygiene and activities of daily living, to fulfill role responsibilities, and physical functions, such as sleep and weight fluctuations.
3. *Medical, addictive and psychiatric comorbidity*—This rating measures potential complications to the course of the presenting or most prominent condition due the coexistence of additional disorders. The criteria specify the degree to which the presence of additional disorders prolong the course, increase the severity of, or impede the ability to recover from the presenting condition. Withdrawal syndromes are considered as medical comorbidity in this context.
4. *Recovery environment*—This dimension contains two subscales, Level of Stress and Level of Support. Criteria for ratings on the stress scale include interpersonal conflicts or harassment, life transitions, interpersonal or material losses, environmental threats, and perceived pressures to perform. On the support scale, criteria delineate the degree to which support is available from family, friends and professional sources, and the likelihood that these supports will be able to participate in care.
5. *Treatment and recovery history*—This scale considers past experience and response to treatment and the durability of any recovery achieved. Criteria for this rating include the intensity of treatment experienced, the degree of success, and the extent and durations of recovery periods. Recent experiences and responses are weighed more heavily than more remote episodes.
6. *Engagement and recovery status*—This rating measures a person's capacity for change and criteria on this scale include the ability to recognize one's difficulties, current stage in the process of change, one's ability to engage with potential sources of aid, and the ability to accept responsibility for maintaining health.

An assessment may be used for initial placement recommendations, or for determination of continuing care needs. The system is based on a dynamic understanding of the course of an illness, and so the assessment should be repeated as frequently as indicated clinically. There will be some cases where behaviors will change very rapidly (i.e., a person who presents with intoxication and who sobers up over the course of several hours) and other cases where circumstances are unchanged for extended periods of time (i.e., a person with schizophrenia who is stabilized with treatment and support). In general, ratings will need to be repeated most frequently during periods of greatest acuity and instability.

Levels of Care

Six "Levels of Care" are defined by this instrument. Each level of the service continuum is described in terms of four variables: (1) Care Environment, (2) Clinical Services, (3) Support Services, (4) Crisis Resolution and Prevention Services. The LOCUS levels of care are better conceived of as levels of resource intensity. Each describes a flexible array of services which, taken individually, may span more than one level of care. For example, case management may be used in Levels II, III, and IV and supported housing is available in Levels I through IV. Although there will be some overlap between adjacent levels of care with respect to the "menus" of services offered, and significant variability in the constellation of services required by a person at particular level of care (reflecting the individualization of the service plan), *on average* service utilization becomes progressively more intensive (and expensive) as one moves from the lower to the higher levels of care. A description of each level of care follows:

1. *Recovery maintenance and health management*—this is the least intensive level of care and is designed for persons who have completed treatment at a more intensive level of care and who require minimal professional support to maintain their recovery. Services may be provided in a clinic or in the community and facilitation of access to social support services may be provided if necessary.

2. *Low intensity community based services*—are provided to persons who have active, but not significantly disabling disorders. Clinical contacts will usually occur about once a week and may include a variety of treatment modalities. They will often be provided in a clinic type setting, but may be provided in various community settings as well. Extensive case management will generally not be required, but supported housing may be needed in some cases. Access to other types of supportive services can be facilitated.
3. *High intensity community based services*—are intended for persons who require more intensive support, but are able to live in the community. Services may be provided in a clinic or may be community based. Professional contacts will usually occur several times per week, often in extended sessions. Multimodal treatments and easy access to clinical services at all hours should be available. Case management and supported housing will frequently be employed. Access to other supportive services will be facilitated as needed.
4. *Medically monitored nonresidential services*—are the most intensive of the outpatient options and are appropriate for persons who are capable of living in community settings, but only with significant support and intensive treatment and case management. A structured treatment setting with clinical contacts for extended periods on most days is available with 24 hours availability of clinical staff by phone. A variety of treatment modalities can be employed and necessary supportive services can be arranged, including services such as day care for dependent children. Partial Hospital and ACT programs would be included in this level.
5. *Medically monitored residential services*—treatment and other supportive services are provided in the context of a residential setting, but the facility in not locked. Treatment is provided on site and most contact with the community takes place in the context of some type of supervision. The setting provides adequate living space and ensures that all material needs are met. The facility is staffed 24 hours daily, medications are monitored, and psychiatric contacts should occur about once per week. Structured social, educational, and rehabilitative activities may be employed as needed.
6. *Medically managed residential*—is the most intensive level of care available and will be provided in the context of a locked setting capable of providing close monitoring and in extreme cases, seclusion and/or restraint. Psychiatric, nursing, and medical services will be available on site or in close proximity 24 hours daily with a capacity to respond quickly when needed. Physician contact will generally occur on a daily basis and medication will be administered by the staff. Multimodal treatment will be available. All material needs will be provided, as well as support of activities of daily living. Liaison with community based resources and supports will be an essential element of provided services.

Although not a Level of Care per se, *Basic Services for Prevention and Health Management* are also defined. These Basic Services are available to persons at all levels of care in the continuum as well as community members who have not required any ongoing forms of care recently. They include a variety of activities related to the prevention of illness, or the minimization of distress during periods of crisis such as screening programs, outreach to high risk populations, supporting victims of trauma, education, consultation with primary care providers, and environmental assessments. Although some of these services may be provided in a centralized location, most of them will occur in community locations.

Placement Decisions

Criteria are provided for each level of care indicating the most appropriate dimensional ratings for the particular level of care and the composite scores required for eligibility. In some cases, independent criteria (such as suicidal intentions) are indicated which supercede other requirements, and automatically recommend the described LOC. A simplified methodology for

AACP LEVEL OF CARE DETERMINATION GRID

Dimensions \ Level of Care	Recovery Maintenance Health Management Level 1	Low Intensity Community Based Services Level 2	High Intensity Community Based Services Level 3	Medically Monitored Non-Residential Services Level 4	Medically Monitored Residential Services Level 5	Medically Managed Residential Services Level 6
I. Risk of Harm	2 or less	2 or less	3 or less	3 or less	④ 3	⑤ 4
II. Functional Status	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
III. Co-Morbidity	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
IV A. Recovery Environment "Level of Stress"	Sum of IV A + IV B is 4 or less	Sum of IV A + IV B is 5 or less	Sum of IV A + IV B is 5 or less	3 or 4	4 or more	4 or more
IV B. Recovery Environment "Level of Support"				3 or less	4 or more	4 or more
V. Treatment & Recovery History	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VI. Engagement & Recovery Status	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
Composite Rating	10 to 13	14 to 16	17 to 19	20 to 22	23 to 27	28 or more

❍ indicates independent criteria - requires admission to this level regardless of composite score

* Unless sum of IV A and IV B equals 2

Fig. 43.1 The LOCUS quick reference placement grid

arriving at placement recommendation is provided in two forms. A placement grid summarizes placement criteria for each level of care and provides a very accurate estimate of the LOC recommendation (Fig. 43.1). A Level of Care Decision Tree is also provided and comprises the algorithm which determines the definitive LOCUS recommendation. A computer assisted version has also been developed incorporating the decision tree algorithm to provide the placement recommendation instantly following completion of ratings in all six dimensions (Sowers et al. 1999).

Child and Adolescent LOCUS (CALOCUS)

The CALOCUS was developed in 1998 and follows the general format of the LOCUS for adults. It is modified to incorporate principles of child and adolescent development, a family and youth empowerment focus, and an emphasis on community based systems of care (Sabin and Daniels 1999). Developmental Disabilities are added to the comorbidity scale and the concept of resiliency is added to the treatment/recovery history scale. Two alternate subscales were developed for the engagement dimension, one for youth, the other for primary caretaker. Only one of these scales is selected, depending on the clinical circumstance (Sowers et al. 2003). Likewise, the levels of care in CALOCUS are modified reflecting wrap around approaches and the broader community service collaboration required to meet children's needs. The similarities between the two instruments make transitions between child and adult service systems go more smoothly and help bridge the gap between the two treatment communities. They both encourage a consistent and intuitive clinical thinking process, which is useful regardless of

what service system is involved. Both instruments use the same scoring system and the same algorithm to guide placement recommendations. Both have established their reliability when scored by a variety of clinicians and the validity of their recommendations.

Extended Applications

Although these instruments were developed primarily to guide service intensity placement decisions, the potential for their broader application is easily apparent. The dynamic nature of the composite and dimensional scores when plotted against time, allows us to track the course of illness and disability as well as service utilization. This information is valuable not only for the clinical care of individuals, but when taken in aggregate, is quite useful for system wide service planning.

Another aspect of the design and use of these instruments that has become increasingly valuable is their ability to facilitate collaborative interactions between the service user and the service provider. They allow the service user to actually participate in the assessment process, and provide a coherent, intuitive and fully transparent rationale for level of care recommendations (Sabin and Daniels 1999). That these recommendations are based on a consistent and universally applied process removes doubts about clinician or system bias. In addition, the dimensional and quantitative measures of need translate very easily into a prioritized listing of the issues that need to be addressed in the recovery plan to allow a service user to progress to lower levels of service need. In providing a framework upon which a person centered treatment plan may be built, a truly client driven planning process can be realized without the need for prohibitive expenditure of clinicians' time and productivity. A fully integrated clinical record is obtained with the addition of progress documentation keyed to the issues in the treatment plan, creating a continuum from assessment to treatment plan to progress notation to transition planning. This will also result in continuity of documentation from one level of care to the next when used across the system of care (Sowers et al. 2003).

The LOCUS/CALOCUS design is easily adaptable to computer applications and integration into electronic medical records. LOCUS/CALOCUS software provides placement recommendations immediately after scores are entered and additional software uses the scores to suggest issues that should be addressed in the treatment plan. It is then able to provide a series of menus with suggestions for strengths, objectives, actions, measures and interventions that can be selected or customized by the service user and provider to construct a person centered recovery plan in which everyone has an investment. The interactive and collaborative process encouraged by LOCUS/CALOCUS is further facilitated by their inclusion in the EMR. It provides a solid foundation for implementation of recovery oriented systems of care.

Although these instruments have never been validated as outcome instruments, many users have suggested their usefulness for this purpose. Whether or not they are used formally or informally in this way, we have seen that LOCUS and CALOCUS are useful not only for their intended purpose of guiding service intensity assignments, but also a variety of other clinical functions, most importantly in providing a framework for recovery oriented services, rapidly becoming a priority for most systems of care.

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The Medical Director in Community-Based Mental Health Care

44

Stephen Rosenheck and Jules M. Ranz

How the Medical Director Arrived

De-institutionalization and the development of community-based care for the severely mentally ill began in the United States in the late 1950s and accelerated in the second half of the 1960s (Mechanic and Rochefort 1990). In the late 1970s, literature began to appear specifically concerned with the role of the psychiatrist in the community-based system that by then had taken shape (Winslow 1979; Ribner 1980; Langsley and Barter 1983; Donovan 1980).

The picture this literature presented was distinctly negative. Focused in particular on the federal community mental health centers (CMHC) program which had a high profile and on which data was collected, the literature documented, first, that the average of number of full-time equivalent psychiatrists per center dropped from 3.1 to 2.4 between 1970 and 1975 (Winslow 1979) and, second, that proportion of CMHCs run by psychiatrists dropped rapidly from over 50% in 1971 (Pollack and Cutler, 1992) to 26% in 1977 (Ribner 1980) and to 8% in 1985 (Knox 1985).

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Anecdotally—but with strong conviction—this literature also reported that psychiatrists, were feeling increasingly alienated from community mental health organizations as a workplace, because they had legal responsibility for patient care, but no organizational authority. To borrow a phrase from T.S. Eliot, their organizational role had been reduced to one of "ragged claws," doing little more than writing prescriptions.

To explain this disturbing situation, the literature cited a number of mutually compounding factors. First, since psychiatrists are expensive, CMHCs had an incentive to use them for the prescribing task they alone could perform and to employ less expensive professionals for administration. Second, psychiatrists are not trained in administration and often lacked the knowledge and skills required to navigate a fiscal, political, and regulatory environment that was becoming ever more complex. Third, since psychiatrists could often earn higher incomes in private practice than in CMHCs, they had a strong financial reason to leave. Finally, the clinical population CMHCs served tended to have lesser clinical problems and not severe mental illness. This clinical fact supported a social model of mental health treatment that left the medical model largely in eclipse.

By the 1990s, a marked change set in, however, and literature on the role of the psychiatrist in community-based care started to become more positive (Pollack and Cutler 1992; Ranz et al. 1997; Stein 1998; Diamond et al. 1991). One critically important reason was accumulating evidence that in community mental health care

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organizations a leadership role was being restored to psychiatrists through the establishment of a formal position separate from CEO but still high in the table of organization, a position frequently titled "medical director."

The first sign of this development was publication by the American Association of Community Psychiatrists (AACP) of Guidelines for Psychiatric Leadership in Organized Delivery Systems for Treatment of Psychiatric and Substance Disorders (AACP 1995). This document aimed to codify existing practice as well as promote a continued growth of psychiatric leadership in the future. At the same time, a survey of psychiatrist job descriptions in CMHCs conducted by Diamond et al. (1995) revealed that an official medical director position existed in 142 of 214 (69%) centers responding. More evidence emerged a few years later, when one of the present authors surveyed the entire membership of the AACP and found that with 479 questionnaires sent out and 286 returned, 58% of those responding were in medical director positions (Ranz and Stueve 1998).

By now, the ubiquity of the medical director role in community mental health is recognized and generally taken for granted. An indicator of this change is that the first edition of the *Textbook of Administrative Psychiatry* (Talbott et al. 1992) had no reference to "medical director" in the index. Ten years later, the second edition of the book allotted the topic an entire chapter (Pollack and Minkoff, in Talbott et al. 2001).

Why It Happened

Eilenberg et al. (2000) provide a substantial and succinct summary of current thinking on why the medical director position became widespread.

> Deinstitutionalization, a renewed emphasis on the care of chronic mentally ill persons, the development of effective medication treatments for severe mental illness, and the explosion of biologic research all led to an increased need for psychiatrists in CMHCs (Beigel 1984; Okin 1984). In addition, regulation of community mental health services increased as funding evolved from block granting towards third party reimbursement. Government agencies and third party payers created regulations that tied reimbursement to the requirement for medical supervision of treatment. (Diamond et al. 1995)
> As community mental health organizations recruited physicians back into service, the need for medical supervisory structures became apparent. (p. 290)

This explanation is valid, but it is not quite sufficient by itself. It conveys an impression that because the emergence of the medical director position helped correct idiosyncratic excesses and errors in the early history of the community mental health care, the new position was idiosyncratic to the community mental health system, as well. In truth, as we discuss later in this chapter, the position of medical director emerged not only in community mental health during the second half of the twentieth century, but also in general hospitals and nursing homes and thus represented a much broader development in American health care as a whole.

The Medical Director Responsibilities and Subtypes

The responsibilities of the medical director in community mental health are catalogued in the AACP model job description, as follows (AACP 1995):

"Model Job Description for the System Medical Director"

Responsibilities:
Unless the Chief Executive-Officer (CEO) is properly trained and qualified to serve this purpose, the Medical Director has ultimate authority and responsibility for the medical/psychiatric services of the System. Specifically, this includes responsibility for:

1. Assuring that all system patients receive appropriate evaluation, diagnosis, treatment, medical screening and medical/psychiatric evaluation whenever indicated, and that all medical/psychiatric care is appropriately documented in the medical record.
2. Assuring psychiatric involvement in the development, approval, and review of all policies, procedures, and protocols that govern clinical care.

3. Ensuring the availability of adequate psychiatric staffing to provide clinical, medical, administrative leadership, and clinical care throughout the system.
4. Developing job descriptions for staff psychiatrists that are comprehensive, and permit involvement in therapeutic and program development activities, as well as application of specific medical expertise.
5. Recruiting, evaluating, and supervising physicians (including residents and medical students), and overseeing the peer review process.
6. Assuring that all clinical staff receives appropriate clinical supervision, staff development, and in-service training.
7. Assuring, through an interdisciplinary process, the appropriate credentialing, privileging, and performance review of all clinical staff.
8. Providing direct psychiatric services.
9. Advising the CEO regarding the development and review of the System's programs, positions, and budgets that impact clinical services.
10. Assisting the CEO by participating in a clearly defined and regular relationship with the Board of Directors.
11. Participate with the CEO in making liaisons with private and public payers, in particular with Medical Directors or equivalent clinical leadership in payer organizations.
12. Assuring the quality of treatment and related services provided by the system's professional staff, through participation (directly or by designee) in the system's ongoing quality assurance and audit processes.
13. Providing oversight to ensure appropriate continuum of programs, level of care criteria, standards of practice, and psychiatric supervision for each program. Internal review of level of care determinations and appeal of adverse UR decisions is an additional component of this process.
14. Participating in the development of a clinically relevant, outcome evaluation process.
15. Providing liaison for the system with community physicians, hospital staff, and other professional and agencies with regard to psychiatric services.
16. Developing and maintaining, whenever possible, training programs in concert with various medical schools and graduate educational programs.

The Medical Director, by licensure, training, and prior clinical/administrative experience, shall be qualified to carry out these functions, and shall have an approximate minimum of 50% of his/her time allocated to administration. In all but the smallest settings, this position should be no less than 32 h per week.

Since this comprehensive list only provides a general model, the present authors and colleagues have undertaken research designed to gain further knowledge about the medical director position in practice. The research developed a questionnaire that classified the activity of community mental health psychiatrists into three categories: (1) direct clinical service (2) clinical collaboration (meaning clinical consultation or supervision), and (3) administration. It then surveyed in succession graduates of the Columbia University Fellowship in Public Psychiatry and the entire membership of the AACP (Ranz et al. 1997, 2000).

The central finding of the surveys was that in practice the medical director position falls into a complicated set of subtypes. To begin with, in practice the medical director exists not only at the agency level, as the AACP model job description tends to imply, but at the program level as well. As one would expect, agency medical directors engage in administrative tasks more than program medical directors. Interestingly, however, the survey also found that program medical directors do the same amount of direct clinical service as staff psychiatrists, but that they do significantly more clinical collaboration and administration and have greater job satisfaction.

Because clinical caseloads are not lower for program medical directors, one might wonder whether creating such a position amounts to little more than having the title of medical director on paper, but not in reality. In fact, the position of medical director legitimizes and facilitates the performance of collaborative activities that are associated with higher job satisfaction. Nonetheless, it is worth

> considering that some of the increased satisfactions may indeed come from the title alone. The perceptions created among staff by a job title such as "medical director" include an expectation of leadership, and if the person filling the position has true leadership and administrative skills, he or she will almost certainly be looked to for guidance. (Ranz et al. 1997, p. 919)

Even though the respondents indicated that this greater job satisfaction is due to the performance of clinical collaboration, in fact job satisfaction was correlated with the performance of administrative tasks (Ranz and Steuve 1998).

The surveys also found something further. Both at the agency and program level the medical director's span of authority divides into three categories—(1) authority over medical staff alone, (2) authority over medical staff and other clinical staff (3) authority over all staff, clinical and administrative.[1] Among agency medical directors approximately one third fell into each of the three categories. Among program medical directors, somewhat more than one third supervised only medical staff and somewhat less supervised all staff.

It is important to note that in the first and third categories the authority of medical director over other staff is formal line authority and in that sense straightforward. In the first category the medical director has line authority only over other psychiatric staff. In the third category, she/he has line authority over all employees.

In the middle category, however, the authority of the medical director over other staff is more complex. While the policy manual or table of organization grants him or her some authority over all clinical staff, in practice this designation means formal line authority only over other psychiatric staff and over a limited number of high risk clinical decisions agency-wide. The majority of clinical director's authority over the nonpsychiatric clinical staff must be informal authority instead.

This informal authority derives from three primary sources: (1) the fact of a high level formal title, (2) the status of the medical degree, (3) the proximate relationship of the medical director to the agency CEO.

The proximate relation of the medical director to the CEO is somewhat complicated as a source of power and has been discussed in depth by Eilenberg et al. (2000). This paper explains that the relationship between the medical director and the CEO can be used externally to navigate problems in a CMHC's environment and internally to generate both quality improvement projects and program development. It is the potential of the relationship to generate internal change spotlights the medical director's informal authority over nonpsychiatric clinical staff.

Quality improvement and program development projects often originate as the medical director's idea. Since they require that clinical staff engage in new tasks, however, the medical director cannot as a rule bring the ideas to fruition alone. Rather, the medical director must convince the CEO that a given idea is worthwhile and then develop a collaborative strategy to accomplish implementation. If a clinical director abstains from activating this process of origination and collaboration, the informal authority over clinical staff latent in his/her position will largely lie fallow.

Above the Single Agency Level

Pollack and Minkoff (2001) enlarge the set of subtypes delineated in the previous section with a discussion that focuses on the emergence of a medical director position above the single agency level.

> Over the past decade CMHCs—and other formerly "public mental health" entities—have been steadily transformed by a variety of forces into what Ranz et al. (1997) have termed *community behavioral health provider organizations* (CBHPOs), which must be flexible, entrepreneurial, and fiscally accountable, much like private businesses…
>
> Increasingly, CBPHPOs are integrating horizontally into networks and vertically into complex systems to respond to payer demands for broader geographical (regional or statewide) contracting and comprehensive service systems to maximize continuity and utilization efficiency. This has resulted in a dramatic expansion of organizational complexity….

[1] In present usage only the first category is universally referred to as "medical director." The second category is often referred to as "clinical director," and the last category simply as "director."

> As CMHCs have evolved into CBPHOs and even larger integrated delivery systems or networks of CBPHOs, and as similar changes have occurred elsewhere, the earlier guidelines for psychiatric leadership have remained relevant but the specific demands of the leadership role have become increasingly complex. (pp. 84–85)

In describing this high level medical director position, Pollack and Minkoff emphasize that its execution requires technical administrative skills that psychiatrists often find foreign but which are indispensible to ensure efficient, high quality care. They divide the requisite skills into four categories:

1. Learning to Use Management Tools. This category includes the following:
   - Developing and using protocols, policies, and procedures to standardize administrative and clinical functioning.
   - Developing and using job descriptions, productivity standards and employee instruments to monitor the performance of clinical staff, which transmit the values of the organization and justify staffing decisions.
   - Developing basic competency in fiscal, regulatory, and reimbursement issues to be able to address billing and budgetary problems in a helpful way and to integrate clinical sensibility into the solution of official problems (p. 86).
2. Using Management Tools to Enhance Clinical Quality. This category consists in mastering the methods of continuous quality improvement or total quality management to monitor and upgrade the quality of clinical care.
3. Keeping Pace With Management Technology. This category refers to "increasing familiarity with computer technology, implementation, and management of information systems, outcome measurement, and data."
4. Maintaining a Collaborative Presence in the Management Team. This category means that

> As the demands on organization managers become more complex and fiscally driven, the medical director is likely to identify less and less with administrative concerns and may retreat increasingly into the clinical role…The medical director cannot give up on the management team, however stressful such continuing engagement may be (p. 89).

Managed Behavioral Healthcare

Despite their focus on the medical director position above the single agency level, Pollack and Minkoff cover the topic only in large *provider* organizations, not in *managed care organizations* that administer capitated premiums for a designated set of beneficiaries. To our knowledge, the only paper on the latter topic in the entire psychiatric literature is a first person account by Ekong (2008). This paper concerns work in a Medicaid managed care organization, however, and is directly relevant to community mental health.

Ekong works as assistant medical director for psychiatry in a Medicaid managed care organization that is a private for-profit corporation. She explains that she is strongly committed to community psychiatry, that she previously served as assistant director of a publicly funded hospital-based outpatient clinic, and that she strongly believe that in her present position she believes is able to accomplish much more than before.

Ekong reports that she spends 60% of her time on utilization review and 40% of her time on quality management. With respect to utilization review, she explains that consistent with the literature on managed care as a whole, she renders denials quite rarely. When she does deny authorization, she is often confident that she is blocking misallocation of resources. In some instances, however, she finds the decision agonizingly difficult, particularly when she is certain that patient's mental status does not warrant ongoing lengthy hospitalization, but can see that resources for a good discharge plan are thin.

With respect to quality management, Ekong does strenuous work with network providers both to develop viable discharge plans for individual patients and to strengthen the system of provision in a given location as a whole. In addition, she also initiates education projects both with network providers and with the managed care company's own staff.

Ekong concludes her paper by reminding the reader that Medicaid managed care organizations are an integral part of the community mental

health system in many locations and by asserting forcefully that the position of Medicaid managed care medical director is a highly meaningful role:

> As I have alluded to previously, the lack of a coherent and unified health system is one of the greatest challenges to successfully achieving the goal of optimal and efficient behavioral health. Within each locality there is little communication amongst agencies, schools, hospitals, and clinics. Members who move back and forth through these sectors can be assured of having to restate their entire histories with each episode in each sector, or risk being treated as a blank slate. Similarly, there is no process for the communication of resource deficiencies or excesses within and across localities….To a large extent this is why MMC companies exist—to help provide coherence and unification. It is the MMC companies that are charged with ensuring that available resources are identified and used appropriately. And it is the MMC companies who are charged with ensuring member follow-up and education….
>
> In choosing medicine as a career, I hoped to be able to create positive change across large populations. I was not sure how I would achieve this goal, but I find that I am doing so through my work at a managed care company. (p. 42)

A Current Informal Snapshot

Since very little has been published on the role of the Medical Director since 2001, in preparation for this chapter the authors conducted an informal survey of AACP members and graduates of the Columbia University Public Psychiatry Fellowship Medical directors functioning at program levels continue to spend the bulk of their time (in some cases, 70% or even more) performing direct clinical service. This is even true for at least some of those serving as agency level medical directors. Other activities carried out by medical directors very frequently include interactions with other agencies or providers (boundary spanning), regular interactions with the executive or program director (sometimes involving the entire executive team), interactions with clinical staff and participation in routine administrative meetings. Activities carried out fairly often are participation in program and policy development, supervision and retention of psychiatrists and, at least at the onset, development of electronic medical records. Activities carried out to some extent include advocacy, recruitment and participation in program evaluation or continuous quality improvement and teaching. Activities mentioned less frequently included interactions with boards of directors and being available for troubleshooting.

Activities that are most often identified as professionally satisfying include participation in program and policy development and interactions with the executive or program director. Others commonly mentioned included providing direct clinical services, interactions with other agencies or providers (boundary spanning), and interactions with clinical staff. Others mentioned somewhat less often, included participation in program evaluation, interaction with consumer groups and the opportunity to promote recovery.

The activity most often identified as creating headaches was difficulties in recruitment of psychiatrists, followed by dealing with difficult staff. Also mentioned frequently were supervision and retention of psychiatrists and interactions with certification and regulatory agencies.

The Medical Director Role in the Broader Context of Health Care

We have seen that the medical director position is by now very well established in community mental health care and that in practice it assumes a wide variety of forms. To locate this configuration in a broader context, we return to our observation at the start of this chapter that in second half of the twentieth century the medical director position emerged not only in community mental health but also in general hospitals and nursing homes, institutions that play a far more dominant role in American health care overall.

Sociology provides the tools with which to understand this phenomenon. To begin with, sociology has long delineated two basic forms of authority for exerting control over the workforce in modern society. One is bureaucratic hierarchy. The other is collegial, self-regulation by an organized profession (Heydebrand 1973).

As a corollary to this conceptualization, sociology has also explained that it is inherently difficult to combine these two forms of authority in one organization and, further, that the birth of modern medicine rendered the difficulty particularly acute in the institution of the modern hospital.[2] Hospitals are complex organizations and inherently bureaucratic. At the same time, however, the advent of modern medicine enormously elevated the status of physicians and made them the premier example of a profession accountable only to itself (Heydebrand 1973).

In the first half of the twentieth century, the institutional solution to this sharp contradiction in hospitals was the development of an organizational structure with two separate lines of authority (Smith 1958). One line was bureaucratic and was headed by the hospital CEO. The other line was "medical." It consisted of a self-regulating physicians association, headed by an elected chief of staff. In the daily operation of the hospital, vitally important task of integrating these two lines of authority rested in the role of the nurse (Heydebrand 1973).

In the second half of the twentieth century, however, the collegial medical line of authority proved insufficient because of the growing complexity of hospitals and of the fiscal and political environment around them. As a result, a new position, a medical director employed by the hospital in a full-time administrative role, emerged either in place of or alongside the elected chief of staff (Williams 1965).

> Although the chief of staff position has worked well in the past, this role must be reevaluated in the light of changing times. Should not the manager of the most important department in the hospital have continuity of office, training in management leadership techniques, as well as clinical experience, so that he can pursue all the administrative details for which he is responsible and be free of economic worries?
>
> The fact that a full-time medical director is present to assume the responsibilities of the traditional chief of staff does not prevent the medical staff from governing itself. He does not preside over the executive committee who has been appointed by them with the approval of the board of trustees. The medical director serves as the secretary of the executive committee, as the resource person and catalyst, as a guide, and at times as a conscience of the executive committee….
>
> The medical director achieves his objectives—which are the same as those of the staff and the board—by close cooperation with the staff and by gaining their respect and trust. He cannot work by the authoritarian approach alone. (pp. 80 and 84)

When we turn to nursing homes, the history of how the medical director position emerged has been excellently recounted by Pattee (1995). The story is different from that which occurred in hospitals in many respects, but in some ways it remains fundamentally parallel at the same time.

In outline the essential points are as follows. (1) Up until about 1950 nursing homes did not have tradition of physician presence at all. After that time, however, the standards of modern medicine began to require a change. (2) When this change occurred, it was taken for granted that the chief M.D. in nursing homes would be a medical director with authority unto himself, not subject to the authority of nursing home CEO. (3) Increasing environmental complexity, embodied in the passage of Medicare, made the medical director position in nursing homes universal, because of a federal government regulation that in order to be eligible for Medicare payment, nursing homes had to include a medical director in the table of organization.

When we step back and view as a single whole the process by which the medical director position developed in community mental health organizations, general hospitals and nursing homes, respectively, it leads the following picture. In each institutional sector the development and character of the medical director position was shaped by factors idiosyncratic to that sector alone. At the same time, however, in every sector the process was driven by two underlying, long-term structural features—the autonomy of the modern medical profession and the steady increase of institutional complexity in modern health care.

As a result both *within* community mental health care and *across* institutional sectors in

[2] Here is it important to recall that prior to about 1870 hospitals were a place where the poor went to die, but that after the advent of modern medicine they become by 1930 a place where citizens of all classes went to be treated (Starr 1982)

American health care as a whole there exists a pattern that is essentially the same. Specific contextual factors make the medical director position very heterogeneous. At the same time the two underlying structural factors identified above make it an organizational constant throughout.

It is likely that in the future the medical director position will continue to develop and differentiate both in community mental health care and in American health care overall. At the same time, there is every reason to believe that at both levels the pervasiveness and importance of the position will persist.

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Program Evaluation and Quality Management

45

Robert Savage, Patricia F. Cornett, and Natalie P. Goodwin

Introduction

The steady outcry for demonstrating quality outcomes for community psychiatry and public mental health programs is long standing and has been responded to in various ways—from a collective yawn in some quarters to outstanding efforts and advances in others. While most of the laborers in the mental health field are highly conscientious and diligent in providing proven, effective and high-quality services, the ability to demonstrate that this is the case can be quite challenging. The mechanics of program evaluation can be daunting when working at the level of an agency or mental health system. More practical efforts typically examine new or distinct programs of limited size and scope and employ methods usually seen in experimental studies of mental health interventions, or quasi-experimental approaches without a defined comparison or control group. Repeated measures approaches can lend themselves to program evaluation projects where baseline data is collected and follow-ups occur at subsequent intervals comparing the same individuals to themselves over time. In addition to these well-established approaches to program evaluation, other valuable and sometimes less demanding methods have been developed. These include program fidelity measurement, quality of life and treatment satisfaction surveys, organizational readiness and atmosphere surveys, evidence-based practice implementation, and reference-based benchmarking methodologies.

The end result of any of these approaches to program evaluation is the demonstration of program impact or effectiveness, both clinically and in terms of cost of services. Recently, the focus has shifted to the overall value of health care and human service delivery systems. Concurrent with the outcome-based evaluation (OBE) movement has been the quality movement. Quality management concepts and measurement methods have taken root in business, education, health care, and human services beginning in the middle of the last century (Deming 1913) and continue to stand as desired and necessary goals toward which many organizations continue to aspire with varying degrees of success. The quality movement takes the findings and data generated by various measurement approaches available to a system and

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utilizes that information to provide formative feedback to individuals, agencies, and community psychiatry systems of care at the local, national, and international level. Ideally this feedback informs the individual case manager, social worker, psychiatrist or other provider, and management staff to help them improve their role in the service delivery system. The ultimate goal is to positively impact the lives of the consumers of mental health service. Quality of care and satisfaction with care is also highly important to those funding the care, both private and public payers. Moreover it is vital to be able to demonstrate the effectiveness, quality, and value of mental health service to the community at large. The following is a discussion of approaches to program evaluation, measurement tools for consideration, and methods for collecting and disseminating information.

Established Approaches to Program Evaluation

Community-based psychiatric and other programs are typically evaluated using OBE. The purpose of OBE is to evaluate whether these programs are providing adequate education, health care, and human services to the individuals for whom they are intended and to demonstrate a programs effectiveness and efficiency to stakeholders, supporters, and promoters (Roberts and Steele 2005; Schalock 2001). It also helps psychiatric programs and policy-makers understand social problems affecting communities, what type of services community psychiatric programs need to provide to the public, utilization of those services, and effectiveness of those services (Gowin and Millman 1981) as well as evaluating efficacy, effectiveness, practice, and service system research of programs (Roberts and Steele 2005). Types of OBE evaluative methods include participant observer and focus group evaluation (grounded theory), effectiveness evaluation, impact evaluation, and cost-effectiveness evaluation. Historically, mental health service programs were based more on ideological, political, philosophical, and financial considerations rather than on empirical evidence of what works or not. These practices are no longer acceptable as accountability for expenditures of effort, time, and money in mental health programs and interventions has increased and efforts to evaluate effectiveness of these programs have also increased (Roberts and Steele 2005).

Grounded theory was developed in 1967 to develop a set of concepts that provided a thorough theoretical explanation of social phenomena. It employs the important principles of change and determinism. Change is viewed as a process rather than a destination while determinism is viewed as the concept that individuals have, but maybe do not always utilize the means to control their destiny by their responses to conditions (Corbin and Strauss 1990). Grounded theory is more focused on determining how individuals respond to changing conditions and the consequences of their actions. Data is typically collected from interviews, observations, government documents, video tapes, newspapers, letters, books, or any other method that may provide usable information related to those under study (Corbin and Strauss 1990). Grounded theory uses qualitative methods of evaluating psychiatric outpatient programs by studying significance, theory-observation compatibility, generalizability, consistency, reproducibility, precision, and verification (Gortner and Schultz 1988).

Evaluations of outpatient community psychiatric programs are often derived from (OBEs) that study the effectiveness, impact, and cost-effectiveness of the programs. Robert Schalock, a leader in the field of OBE, developed a method of program evaluation that will be highlighted here given its comprehensive nature and proven utility in education and human services. The purpose of effectiveness analysis, one of the most commonly used OBE techniques, is to evaluate whether the intended goals and objectives of programs have been met. The results of the program provide formative feedback (basis for data-based management) and provide information for programmatic changes. This type of evaluation is very pragmatic, cost-effective, practical, and reduces ethical problems in establishing experimental and control conditions. Typically, comparison designs are used including person-as-own comparison, pre-post change comparison, or longitudinal status comparisons. Of course, the number of assumptions made by the

researcher increases the limitations of the precision, certainty, comparability, and generalizability of the analysis. Despite these limitations, these analyses provide essential information that can be used for data-based management, reporting, and program change purposes (Schalock 1995, 2001).

Impact evaluation is another outcome-based analysis that is employed to determine whether a given program made a difference as compared to either no program, or an alternative program (Schalock 1995, 2001). This information provides information of whether the difference the program made is significantly different and if continued funding and continuation of the programs is warranted. This is determined by focusing on the programs' specific impact on consumers, determining whether the impact can be attributed directly to the intervention or services being evaluated, and providing feedback to program managers, policy-makers, and funding bodies regarding the impact of the program or public policy being evaluated (Schalock 1995, 2001).

Cost-effectiveness evaluation, the most complex type of outcome-based analyses, seeks to uncover whether psychiatric outpatient programs' benefits are large enough to justify the costs allocated to provide those services. This type of analysis uses comparison analysis of different treatment programs in order to determine the most effective treatment for the cost of the program (Wolff, et al. 1997). This information is vital in determining whether programs are allowed to continue to operate and provide services. Program administrators, funding bodies, policy-makers, and taxpayers want to know if outcomes of programs are effective and cost-effective (Schalock 1995, 2001).

Utilizing Existing Data Sets to Evaluate Services

In the United States, most government agencies and publically funded agencies are required to provide open access to certain general information concerning services provided, accessibility, and the financial and spending information of their particular agencies. Community, state, and national mental health programs collect this information and provide access to this information through their web sites, through publications, and through direct requests. Collected information varies from state to state depending on standards set forth by individual agencies and by state law. Most states collect basic client information/demographic information (race, educational attainment, employment status, veteran status, residential arrangement, and legal status), consumer satisfaction with programs, special incident reports (information on client injury, hospitalization of client on a locked unit/program, suicide attempts, physical abuse, nonconsensual sexual contact, elopement, unplanned evaluation/relocation of clients, and any other special incidents), and medication errors. Other information collected includes consumers' utilization of services of (i.e., whether they are new consumers or whether they are repeat consumers of services) diagnosis of serious mental illness (SMI) and serious emotional disturbance (SED).

Many state agencies and other organizations use these data sources to publish reports (e.g., quarterly reports) that are distributed to the executive planning offices and other stakeholders to monitor progress on priority areas for each service component (e.g., mental illness division, intellectual disabilities division, and substance abuse divisions). Quarterly reports provide information on workload measures (e.g., numbers of individuals accessing services in each region, type of service delivery, inpatient vs. outpatient service, agency utilized, age and gender information), measuring progress toward goals for child, adolescent, and adult continuum of care, measuring outcomes/progress toward fiscal year goals (employment, arrests, and abstinence from substances), measuring progress toward fiscal year goals for waiting list and for transportation.

Benchmarking for Program Effectiveness and Quality Management

Community psychiatry clinics, mental health agencies, substance abuse and intellectual disabilities service organizations can employ a range

of benchmarking techniques to track outcomes in a time- and cost-effective manner. Benchmarking allows an organization to compare its operations to those of similar organizations when data sets are gathered in a uniform manner such as state level community mental health centers. National performance measurement guidelines and data sets exist (Ganju 2006) as well as international benchmarks of mental health care (Hermann et al. 2006c). On a small scale, simple baseline data can provide the foundation for tracking improvement over time. Both baseline data and benchmarks can be used to set goals for organizations to target as areas of quality improvement.

Benchmarking for a service provider organization can include financial benchmarks, organizational, operational, and clinical benchmarks (Lefkovitz 2004). For example, financial benchmarks may include an organizations operating margin, asset to liabilities ratios, net income, and payer mix (Medicaid, Medicare, commercial or private payers, grants and contracts, etc.). They can also include an organizations' total cost per person served and costs by service type or CPT codes. Operational benchmarks can include indicators like provider productivity, access to care information like days to initial appointment following a service request, percentages of no-shows and cancelations, average caseloads for various provider groups; ACT or PACT teams and day program average daily census. Clinical benchmarks often focus the performance improvement light on key areas including annual psychiatric hospitalizations, and state hospital readmissions for a given period (e.g., 30 days post discharge). Client suicide and criminal justice data are also of interest when available. Organizational climate benchmarks are also helpful to track. Areas of interest can include staff turnover and surveys of staff satisfaction in domains such as relationships with supervisors and coworker, compensation and benefits, and attitudes about quality and overall morale. Benchmarking projects can also be used to identify best practices in mental health (Rushing and Lefkovitz 2008), and together these input can become the key source for quality management and performance improvement efforts within agencies and systems.

Statistical benchmarks, representing the level of performance achieved by the best-performing providers, can be used to set achievable goals for improving care, although they have not been widely available in mental health care. A 2006 project examined 12 consensus-based, process-oriented measures from which were developed conformance rates at the provider level. Various rates were reported as statistical benchmarks (means, 90th-percentile results, etc.) for 356–4,494 providers and from 1,205 to 78,627 cases (Hermann et al. 2006a). They looked at measures such as usage of several antidepressant treatments, antipsychotic treatments, and a mood stabilizer for bipolar disorder. Six other measures involved follow-up treatment visit parameters. They concluded that statistical benchmarks can be applied to quality-related data points and that incorporating such benchmarks into quality improvement activities leads to better mental health care and substance-related care and improved consumer outcomes.

Measurement-Based Quality Improvement

Quality improvement and quality management efforts can range from small projects of limited scope and a few key goals to more complex efforts. Complex efforts include formal measurement-based quality improvement (MBQI). MBQI can be routinely conducted by mental health provider organizations (mental health agencies, state and private hospitals, state and national organizations, insurance and health plans), either at their own initiative or at the insistence of payers and oversight organizations. Another complex approach is the systematic implementation of evidence-based practices (EBPs). In the United States this has been undertaken by several state mental health authorities and by other systems of care, working in collaboration with services researchers and stakeholders (Hermann et al. 2006b).

Although they are distinct approaches, MBQI and EBP implementation (EBPI) overlap in their objectives and means. It has been pointed out that there are a number of issues that impact the implementation of EBPs at several levels including the individual, the organization, and society (Schalock et al. 2010). Based on work in the intellectual disabilities area these issues include the need to expand the concepts of internal and external validity, approach EBPs from a systems perspective, integrate various perspectives regarding EBPs, develop and evaluate EBPs within the context of best practices, and develop a set of guidelines related to the translation of evidence into practice.

Community mental health and other human service organizations face numerous challenges in the current financial and regulatory environment. These include demonstrating fiscal and programmatic accountability to oversight bodies and finding methods to use person-centered and organization-based outcomes for quality improvement in a context of continuous performance improvement. Performance and quality improvement concepts such as total quality management (Deming 1913) have existed for some time and more recently clients have redefined themselves as customers or consumers of human services rather than passive patients or service recipients (Schalock and Bonham 2003). To be effective, organizations need to adopt a sound program evaluation model that is acceptable to consumers, providers, and managers which includes a logic model discussed below that helps all stakeholders make sense of inputs and processes and develop outputs that provide valued formative feedback for persons and organizations. Together these elements can be employed to inform management, providers, and the quality improvement process.

In the next section we turn to a brief discussion of evaluation measures that can be employed in the program evaluation process. These include measures of program fidelity, organizational processes and value, and measures of individual outcomes and performance.

Program Fidelity

In evaluating programs, it is first important to understand if the program is being implemented as it was intended. The treatment model chosen by programs is often based on research that has deemed a treatment strategy as empirically supported. The clinical effectiveness of an empirically supported treatment is largely dependent on the fidelity of treatment as it is translated from research to general clinical practice. A well-researched treatment demonstrating positive results in the research setting cannot be expected to produce the same results in the clinical practice if the treatment is not implemented in the expected manner. Fidelity refers to the "the degree to which a particular program follows…a well-defined set of interventions and procedures to help individuals achieve some desired goal" (Bond et al. 2000). Or in other words, fidelity refers to how well an intervention implemented in the clinical setting matches the intervention as it was intended (Hill et al. 2007). The National Institute of Mental Health (NIMH) has addressed the science to service gap and acknowledges that fidelity is essential to delivery of evidence-based treatments. Several studies have indicated that higher fidelity is associated with more positive outcomes, such as decreased hospitalizations, less time in the hospital, and greater retention in treatment (McGrew et al. 1994; McHugo et al. 1999). Research has indicated, even when provided with a manualized format, administrators often make changes to evidence-based treatments, even though they report knowing they should not (Hill et al. 2007). With evidence supporting that treatments are often more effective with higher fidelity, it is important to have measures to assess fidelity. The NIMH has developed recent initiatives to propagate awareness and encourage research related to fidelity of evidence-based treatments being implemented in clinical settings (NIMH 2011).

Fidelity Assessment

To measure fidelity, several issues must be addressed. Fidelity assessment can occur at the organizational level for an assessment of a program at large, or can be more specific to a type of therapy or research protocol. Fidelity assessment requires that treatment components be understood and operationally defined to enable their measurement, and that the source for their measurement be identified (Bond et al. 2000; Mowbray et al. 2003; Teague et al. 1998). In addition, it is important to address what is consistent, unique, essential, incompatible, or prohibited within treatment modality (Bond et al. 2000). Once components are defined and fully understood, assessments can be produced that will allow for the objective measurement of treatment fidelity. After formulation of the fidelity assessment measure, it is important to perform research that supports the psychometric utility of the assessment (Mowbray et al. 2003). The measure should evaluate the implementation of the critical ingredients of the treatment modality and differentiate between other programs in a reliable manner. The measure should also provide program feedback regarding strengths and weaknesses, and allow for the evaluation of trends and outliers. Bond et al. (2000) suggest that in addition to providing evaluation of adherence to treatment models, fidelity assessment can lead to identification of the most critical elements of a program.

Assertive Community Treatment: An Example of Fidelity Assessment

Developed relatively recently, the fidelity assessment for the widely recognized psychiatric rehabilitation program called Assertive Community Treatment (ACT) exemplifies a process for developing a measure of fidelity and an example of a well-described and operationally defined program. The ACT model originated in the 1980s as a treatment method to support individuals living with SMI in community living (Stein and Test 1980). It is recognized as an EBP with a history of consistent results pointing to its effectiveness, especially in reducing risk for repeated psychiatric hospitalization (Bond and Salyers 2004; NAMI 2007). The program involves a multidisciplinary team that meets daily regarding clients and provides community, rather than clinic-based, daily assistance with medications, housing finances, and other daily living concerns. It has been implemented internationally and has several models with varying levels of staffing and service delivery (ACT, and PACT).

Although ACT is well described and manualized (Stein and Test 1980), measures of program fidelity were developed only relatively recently. The initial fidelity scale was developed by McGrew et al. (1994) who outlined a list of the components of ACT, operationally defined those components, and then used experts in the field to rate the importance of the components. Using statistical methods, 73 components were identified as most important and these were later reduced into 17 items grouped into three dimensions of staffing, organization, and service. The measure differentiated between ACT programs and indicated that those with the highest fidelity had the most positive outcomes.

In the years to follow, researchers at Dartmouth produced another fidelity scale for the PACT program called the Dartmouth Assertive Community Treatment Fidelity Scale (DACT). The measure consists of 26 program criteria grouped in three dimensions of structure and content (presence of staff specialties, caseload information, program size, and communication with staff), organizational boundaries (admission and intake criteria, crisis services, discharge procedures), and nature of services (in vivo services, dropout policy, frequency of contact with staff, assertive management, individualized treatment, availability of treatment groups and support system (Teague et al. 1998). The components were defined operationally and put on a five-point Likert scale with a description for each point. The scale differentiated between ACT and non-ACT programs.

The process of creating a fidelity measure for the ACT program provides a guideline for promoting development of other fidelity measures. The fidelity scales used for the ACT programs

could likely be adapted to other programs as well, acting as a stepping-stone for developing fidelity assessments for other programs. As the fidelity assessment results demonstrate, programs with high fidelity are more effective (McGrew et al. 1994; McHugo et al. 1999), therefore exemplifying the importance of assessing fidelity in the context of program evaluation and as a necessary precursor to evaluating program outcomes.

Organizational Process and Values

If a program is not being implemented correctly, measuring outcomes will be flawed; therefore, once fidelity is evaluated and deemed adequate, one can focus on the outcomes of a program. Schalock (2001) describes standards for selecting outcome measures. Schalock suggests that a rationale should exist for selecting measures and that outcome measures should be chosen based on goals for accountability and continuous improvement. Schalock describes that outcome measures can fall into four categories, namely, organization performance/program process, organization value/organizational outcomes, individual performance/program outputs, and individual value/individual outcomes. We have added indicators of health status as well. The following table summarizes these measures.

Table 45.1 Measuring outcomes

Global Outcome Measures	What is Measured	Examples	References
Organization Process	Business aspects of organizations: licensure requirements staff certifications performance indicators financial accountability	Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	JCAHO website
		National Committee for Quality Assurance (NCQA)	NCQA website
Organizational Value	Consumer appraisal consumer satisfaction fidelity of service benchmarks standards of excellence	Consumer Assessment of Behavioral Health Survey	Eisen, et al, 2001
		Mental Health Statistics Improvement Program (MHSIP)	Ganju, et al., 1996 Jerrell, 2006
Individual Performance	Physical and mental health functional status financial and residential status and education development	Global Assessment of Functioning Scale (GAF)	Soderberg, et al., 2005 Anderson, et al., 2003
		Child and Adolescent Needs and Strengths-Mental Health (CANS)	Praed Foundation, 2007, 2008 Olsen et al., 2004
		Adult Needs and Strengths Assessment	Boulet & Boss, 1991
		SCL-90	Eisen et al., 1994, 1999
		Brief Symptom Inventory	Derogatis et al., 1976
		Basis-32	
Individual Outcomes	Quality of life (social relationships, rights, personal dignity, personal development)	SF-36	Dowdy et al., 2005
		Quality of Well-being Scale	Spieth & Harris, 1996
		Lehman's Quality of Life Interview	Lehman, 1988
Health Status Indicators	Metabolic Syndrome	Fasting Blood glucose, HgbAlC	ADA, 2004
		Fasting lipid panels	

National Mental Health Performance Measurement Studies and Other Resources

The National Association of Mental Health Program Directors (NASMHPD) and their National Research Institute (NRI) conducted the Sixteen State Study on Mental Health Performance Measures. They worked to develop and improve and then pilot indicators that were tested in terms of access, appropriateness, outcome, and program management performance on a statewide basis (Lutterman et al. 2003). The numerous measures employed were taken from the NASMHPD Framework of Mental Health Performance Indicators and many are now part of the Center for Mental Health Services (CMHS) Data Infrastructure initiative. A key goal of the study was to provide information on the data collected by the states. Twenty-six work groups were formed and examined a similar number of quality and outcome indicators ranging from satisfaction surveys, living situation, and employment status, to tracking of criminal justice involvement, hospitalization rates, seclusion and restraint, and medication errors to name a few. The guidelines and indicators they developed are applicable to ambulatory care, inpatient and residential services. NASMHPD and NRI analyzed a broad range of indicators and findings and reported on various issues and challenges of this project. This led to an extensive set of recommendations that can be found on their website; http://www.nri-inc.org/reports_pubs/2003/16StateStudy2003.pdf. Other helpful web-based resources for quality measurement are included here for interested readers to examine. The National Inventory of Mental Health Quality Measures is an interactive database found at http://www.cqaimh.org/quality.html and through a link provided by the Evaluation Center@HSRI www.tecathsri.org. Both the inventory of measures and the Evaluation Center toolkit focus on process measures. These are approaches to quality measurement that focuses on the interaction between healthcare systems and consumers of health care. The toolkits summarize principles underlying quality improvement, describe characteristics of process measures and how to select measures meeting an organizations needs, and suggest how quality measures can be used in conjunction with other indicators of quality performance. CMS provides a compendium of quality measures at the following web address: https://www.cms.gov/MedicaidCHIPQualPrac/Downloads/pmfinalaugust06.pdf.

Conclusion

Community psychiatry and the public mental health sector in general serve a population of individuals and their families that typically face more severe levels of symptoms and resulting disability than is seen in the broader, often privately funded and managed, mental health sector. The seriously mentally ill adults and seriously emotionally disturbed children and adolescents that public systems serve need and deserve the highest level of care and the most effective, ever evolving, and improving array of services. While never abundantly resourced in the United States, service demands continue to grow as resources continue to be scarce, facing ever greater pressures. Human services budgets can expand or shrink, with changing local state and federal budgets, and recent times have seen more of the latter. Regardless of the financial climate two major trends have emerged that influence systems of care. Program evaluation methods such as the OBE movement and quality movements such as total quality management have converged upon mental health systems and demand their due. Formal program evaluation methods borrow from the experimental and social sciences and can be used to lay the groundwork and evidence base for new treatments and programs for the seriously mental ill. Program evaluation projects can require considerable effort, expertise, and resources. We have described assessment methods, a range of assessment measures, and several approaches that take components of formal program evaluation and make them less demanding in terms of data collection and management. They provide the needed information about quality of care that providers and systems need for quality management and performance improvement purposes.

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Mental Health Services Research and Community Psychiatry

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Mario Cruz

Introduction

Whether you're a mental healthcare administrator, a medical director of a clinic, or a clinician, questions regarding the quality, cost, and the consumer's perception of the value of your services are (or should be) of great importance to you.

Answers to these questions are vital to what it means to be a community psychiatrist. Though there is no established definition of community psychiatry, most community psychiatrists would agree that they provide services to individuals who are most in need of mental health services, yet confront an array of social, economic, geographic, and psychological barriers to receiving these services. Community psychiatrists are aware of and attempt to address these factors.

In addition to the intervention strategies and skills psychiatrists learn in their general residency training and the individual-level interventions to address community-based barriers to care, community psychiatrists also need skills related to systems-based service delivery strategies.

A system of care is an organized set of processes created explicitly to ensure that patient-care activities occur more consistently than would be likely if they depended entirely on individual practitioners or patients (Solberg et al. 1999). Skills that are needed to address system of care issues can be as varied as: (1) administrative skills to organize services; (2) business skills to prepare budgets for programs; (3) skills to educate and train clinicians and clinic staff in evidence-based practices; (4) skills in the use of financial incentives and/or disincentives to improve the interaction between clinicians and consumers; and (5) skills in developing partnerships with other providers to address gaps in service delivery. These nontraditional psychiatric skills are essential if we are serious about improving care delivery for large groups of individuals, particularly the poor and underserved.

The skills mentioned above have been identified from mental health services research studies. Having a working understanding of the findings from these studies, particularly the evidence-based processes and practices promoted by mental health services research, is another skill set that is valuable to community psychiatrists. For instance, to make decisions on what services we should provide, we need to know how many individuals with a particular diagnosis need our services. In addition, we need to know what services are available to consumers within our system of care, clinic, or hospital. Do our services aid consumers in their recovery and in acquiring the ability to bounce back from life's typical stressors or traumatic events? How do we identify gaps within our service array? How do we decide what services would fill those gaps?

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And, how do we implement those services in the most cost-effective and sustainable way?

To answer these questions, we need scientifically gathered utilization data from our system, clinic, or hospital on the prevalence of certain illnesses. Additionally, we need data on the services our consumers use and the quality of those services. To make decisions on how to improve our services, we need results from well-designed studies that compare the effectiveness of specific interventions in care settings similar to our own and the annual cost of these interventions. Finally, we need proven implementation and sustainability strategies we can apply to implement any new interventions within our system.

Defining Services Research

Addressing the above-mentioned issues lies at the heart of mental health services research. In 1988, the National Institute of Mental Health (NIMH) defined mental health services research as a discipline that places emphasis on "the study of service delivery at three levels—the clinical, institutional, and system level" (Taube and Burns 1988, p. 839). In contrast to basic and clinical sciences research, where the focus is on addressing issues related to the causes and treatment of disease, mental health services research focuses on issues related to the cost, quality, and usability of mental health services in real-world care settings.

Considerable attention has been devoted to distinguishing two domains of mental health services research (NIMH 1991). They are clinical services and service systems research. Clinical services research is closely tied to clinical research. It is concerned with the application of knowledge gained in a controlled research environment to the larger, relatively uncontrolled environment in which the mentally ill actually receive services and live. Its goal is to improve the quality of care of everyday clinical practices so that they provide optimal services informed by our present evidence-base. Examples of major research areas that would be considered clinical services research include identifying risk or protective factors at the individual and community level that are associated with or influence the course and treatment of mental illness; consumer and/or provider factors that influence the accuracy of diagnoses, treatment adherence, and outcomes; and the comparative effectiveness of newly developed research interventions.

Service systems researchers devote their attention to understanding how to provide services efficiently, economically, and equitably. Service systems research covers a broad array of topics. They include identifying the nature and scope of local service needs and the core features of treatment interventions that must be applied uniformly across service settings and all service users to achieve optimal impact. Other topics include:

- Developing the best strategies to implement and sustain evidence-based treatments,
- Allocating financial resources so that consumers and providers have proper incentives to use services appropriately,
- Implementing statutory procedures such as civil commitment, consumer's rights, informed consent, and confidentiality.
- Developing strategies to overcome system-wide issues that impede the access to and quality of services such as stigma within a mental health organization.

Putting Research into Practice

Presently, service systems research methods and strategies are underdeveloped in comparison to clinical services research. The maturity of this mental health services research domain is essential to improving care in real-world settings. For example, despite extensive evidence and agreement on effective mental health practices and interventions for persons with severe mental illness, many of these practices are not employed in typical mental healthcare settings (Drake et al. 2001). On the provider side of this translation equation, the blame for gaps between science and practice has been (at times) placed on the "stubbornness of practitioners insisting on doing it their way" (Green 2008, p. i20), or the "organizational climate" within service agencies (i.e., staff

attitudes toward the work environment and job satisfaction) (Glisson and James 2002). Other factors include the perceived organizational support for quality improvement (Shortell et al. 2004) or dimensions of organizational culture such as shared beliefs on how to deliver quality care and the services that are considered valuable (Shortell et al. 2004). On the scientist side, the blame has been placed on the "smugness of scientists believing that if they publish it, practitioners will use it" (Green 2008, p. i20) and the related failure to be attentive to implementation issues.

The true explanation for why there has been limited uptake of evidence-based practices is more complicated than the above reasons. For example, we know that many promising interventions in controlled environment trials fail to be as effective in real-world settings. One reason for this failure in effectiveness is that many controlled interventions exclude consumers who have difficulty accessing or adhering to care. The characteristics of the excluded consumers may be more consistent with the population we serve than the consumers who were included in the intervention trial.

Other reasons for the ineffectiveness of controlled trial interventions in real-world settings are the costs associated with implementing and sustaining a new intervention and the incapacity of organizations to negotiate change. These issues may cause the community psychiatrist to pause and think whether implementing a new evidence-based practice is practical.

In light of these reasons behind the science-to-practice gap, changes in the process of developing new interventions have been recommended. Specifically, it has been recommended that researchers and clinicians collaborate in all aspects of research from defining the questions that are addressed, to the development of implementation models and strategies (Green 2008; Sullivan et al. 2005).

Another useful way of conceptualizing the purpose of mental health services research that is less broad than the NIMH definition, and more relevant to community psychiatry, is to consider mental health services research as a means of asking and answering questions relevant to service delivery at the policy, system, clinic, provider-consumer, and individual consumer level. This conceptualization of mental health services research is more consistent with the Agency for Health Services Research (AHSR) definition of health services research as "a field of inquiry that examines the impact of the organization, financing, and management of health care services on the delivery, quality, cost, access to and outcomes of such services" (Public Expectations and Health Care Quality 1998).

This chapter will introduce the reader to the core features of mental health services research that are salient to the needs of community psychiatrists. Following this introduction, the chapter will have two main sections followed by a brief summary. In the first section, I will discuss mental health services research that assesses the state of the mental healthcare system. This form of mental health services research is intended to characterize the accessibility, cost, quality, and outcomes of service delivery using epidemiological research survey methods and datasets. Research within this domain is not intended to address problems in mental health service delivery. It is a means of characterizing mental health care from various perspectives within discreet time periods. This form of mental health services research can be used to uncover problems or disparities in mental healthcare delivery and the results can be used for practical purposes ranging from influencing national mental healthcare policy to supporting further investigation into the causes of any identified problems.

In the second section, I will familiarize the reader with various aspects of mental health services translational research. Translational research is a somewhat broad domain encompassing mental health services research that is intended to elucidate factors affecting the cost, quality, outcomes, and access to care. Translation research also includes testing and employing specific strategies and methods to address the above-mentioned factors or implement new interventions in real-world care settings.

In the translational research section, I will also go into more detail about the two differing views of

how knowledge should be developed and translated into evidence-based practices—that being the traditional "pipeline" (Green 2001) model espoused by NIMH vs. nontraditional collaborative research-practitioner models. I will provide an example that highlights the complexity of translation research. Finally, I will describe nontraditional research approaches that include providers and community members in all aspects of research.

System Assessment

To identify problems in care and potential intervention strategies to improve care, you need data on the current state of care provision. Whether you are a State Behavioral Health Medical Director who has been charged with offering recommendations to improve the care of the seriously mentally ill or you are a clinician working in a community-based publically funded mental health center who is concerned about consumers not adhering to treatment appointments, you need information that can direct you to proposing a solution to the problem at hand. Mental health services research that intends to inform funding decisions at the federal, state, local, or program level uses utilization data that have already been collected from community providers within defined periods of time. The scientific method is employed to turn questions into testable hypotheses. Datasets are chosen based on the type of information needed to test a particular hypothesis. Ultimately, standard statistical tests are used to accept or reject the hypotheses.

To highlight system assessment mental health services research, let's look at the development of the movement to enhance mental health services in primary care practice settings. In 1978, Regier and colleagues published one of the most influential articles regarding access to care for mental health services. It was titled, "The de facto US mental health services system: A public health perspective" (Regier et al. 1978). It was thought, and a few studies showed, that primary care clinics were screening and treating a large percentage of mental health consumers (Locke and Gardner 1969; Locke et al. 1966; Shepherd et al. 1966; Regier et al. 1977; Eastwood and Trevelyan 1972; Brown and Regier 1977). However, there was no clear understanding of how essential primary care clinics were to mental health service delivery.

The White House Executive Order of Feb. 17, 1977 established the President's Commission on Mental Health. As a first priority, the White House requested that the Commission seek to identify how the mentally ill were being served, to what extent they were being underserved, and who was affected by such underservice (President's Commission on Mental Health 1977). Regier turned these potential policy-driving questions into study objectives. The study objectives were to: (1) produce the best available estimates of the number of individuals in the population who have mental disorders; and (2) determine from available data the number who are identified and/or treated within specified sectors of the mental health and health services system in a single year (Regier et al. 1978, p. 686).

Regier and colleagues defined the mental health system as a largely unorganized and "de facto" system comprised of four major sectors—A specialty mental health sector (SMH), a general hospital inpatient/nursing home sector (GHI/NH), a primary care/outpatient medical sector (PC/OPM), and a not in treatment/other human services sector (NT/OHS). Thereafter, they combined several epidemiological datasets to assess the national prevalence of psychiatric disorders and another dataset to assess service utilization and combined them to create a dataset that could be analyzed to meet the study objectives.

Epidemiological datasets typically have information on the characteristics of participants at one point in time. However, most mental health utilization datasets look at the volume and type of services over a defined period of time, typically over a 1-year period. To combine these datasets, Regier and colleagues had to create an estimate of the annual prevalence of mental illness by adding an estimate of the number of new cases of mental illness within 1 year (i.e., annual incidence) to the point prevalence estimates suggested by existing epidemiological survey data in multiple communities.

One major issue with most utilization datasets is that the information within them is captured in total, i.e., the volume of different services used in a defined period of time. Rarely is this type of information packaged in an easy way to determine service utilization by a particular person. Consequently, service utilization data will have multiple services linked to each person. To address this issue, Regier and colleagues estimated the total number of individuals with mental illness that were treated in any facility during 1 year (i.e., annual treated prevalence). To do this, they had to remove all service data that were generated from an individual beyond the first service counted.

Their results revealed that 54.1% of all mental health screening and treatment resided within primary care compared to 15% found in the SMH sector. In addition, depression was more often treated in primary care than the SMH care sector.

Subsequent to the publication of this article, there has been considerable research focused on improving the detection and treatment of mental disorders in primary care settings (Brown and Schulberg 1998; Brown et al. 1995, 1996; Croghan et al. 2006; DHHS 2005; Gossard et al. 2000; Katon and Gonzalez 1994; Katon et al. 1999; Kessler et al. 1999; Schoenbaum 2000; Sherbourne et al. 2002; Unutzer et al. 2008; Wells et al. 2004; Simon et al. 2001; Lin et al. 2001; Lave et al. 1998; Arean et al. 2005; Gallo et al. 2007; Oxman et al. 2002; Coyne et al. 1995; Cepolu et al. 2007; Borowsky et al. 2000). This research effort has resulted in the successful development and testing of several evidence-based interventions for the treatment of depression in primary care settings. Regier and colleagues' study highlights how important, and difficult, system assessment mental health services research can be.

Practice Pattern Research

Another example of system assessment mental health services research is practice pattern research. Psychiatry has changed considerably for many of us who trained in or before the 1990s. With the inception of managed behavioral care organizations, coupled with the rise in new pharmacologic treatments, there has been a significant shift in the role psychiatrists play in care. Since the 1990s, psychiatrists principally function as pharmacotherapists, i.e., psychiatrists who solely prescribe medications in brief and infrequent appointments (Stahl 2000). Prior to the 1990s, psychiatrists provided both pharmacotherapy and psychotherapy in longer and more frequent appointments.

Though we all felt the impact of these changes, it was not known if this was a national or local trend. Olfson and colleagues performed an analysis of psychiatrist-reported practice pattern data from the 1985 and 1995 National Ambulatory Care Surveys, an annually conducted survey by the National Center for Health Statistics (Olfson et al. 1999). In this survey, physicians, or their office staff, completed a one-page data form for each visit during a specified 1-week period within a year. Olfson and colleagues extracted information on the characteristics of psychiatric visits in both survey years to estimate changes in practice patterns over time. Compared to 1985, the 1995 survey revealed a significantly greater proportion of psychiatric visits were with older consumers, nonwhite consumers, publically insured individuals, and consumers who paid for their care through a managed care organization. In addition, there was a significantly higher rate of prescriptions and the appointment length was significantly shorter. More recent analyses by Olfson and colleagues show the trend toward psychiatrists practicing solely as pharmacotherapists continues (Olfson et al. 2002; Olfson and Marcus 2009).

These two examples show how valuable system assessment mental health services research can be for identifying potential mental health service needs (Regier and colleagues) or changes in workforce practice (Olfson and colleagues) that suggest a need to reassess workforce training and education (Cruz and Pincus 2002) or for further studies to determine the impact of psychiatrists' role changes on treatment outcomes.

Translation Research

As I mentioned in the introduction, translation research is a broad domain of mental health services research that intends to identify what interventions are effective in real-world settings. Translation research also intends to describe and ultimately address barriers to implementing high-quality care. The National Institute of Health defines the translation of evidence-based practice research as moving scientific knowledge from efficacy-tested (controlled environment) interventions to testing for effectiveness (real-world environment) and acceptability for adoption in practice (Zerhouni 2003).

For this discussion, I will initially familiarize the reader to some terminology. The important terms to understand here are dissemination, diffusion, and implementation. For health care, dissemination has been defined as the targeted distribution of information on evidence-based health interventions (Lomas 2003). In the mental healthcare setting, one example of disseminating information about new evidence-based interventions is by attending a continuing medical education conference on developments in the treatment of bipolar disorder. The information distributed targets a defined population (psychiatrists) and provides information that is evidence-based.

Dissemination should be distinguished from diffusion. Diffusion is the spread and use of new ideas, behaviors, practices, or organizational forms in an unintended or spontaneous manner (Rogers 2003). One example of diffusion is the use of assertive community treatment (ACT) teams to deliver services to consumers with borderline personality disorder or developmental disabilities. The body of evidence supporting the use of ACT with these populations is limited at best. However, using ACT with these groups occurs. Since ACT was never tested on these latter populations, its use would be unplanned.

Implementation is the translation and application of innovations, recommended practices, and policies (Lomas 2003). Implementation research studies the processes and strategies that move or integrate evidence-based treatments into real-world settings. One example of successful implementation would be the spread of stepped collaborative care practice models for the treatment of depression in primary care settings (Gossard et al. 2000; Katon et al. 1999; Schoenbaum 2000; Unutzer et al. 2008; Simon et al. 2001; Gallo et al. 2007; Oxman et al. 2002).

Implementation Strategies

Though most implementation strategies remain poorly defined, they are broadly characterized by the use of "top-down" or "bottom-up" techniques. "Top-down" implementation strategies originate from system or clinical administrators. "Bottom-up" implementation strategies intend to engage clinicians and office staff in the process of changing how they provide care. "Top-down" strategies include evidence-based practice tool kits and algorithms, practice guidelines, system and organizational interventions from management science, as well as economic, fiscal, and regulatory incentive and disincentive strategies. "Bottom-up" strategies include quality-improvement interventions (Shortell et al. 2004; Glisson and Schoenwald 2005; Rubenstein and Pugh 2006) and techniques that engage practitioners and clinical staff in the process of improving care such as the Deming/Shewart Plan-Do-Study-Act cycle (Deming 1986).

Proctor and colleagues developed a useful intervention and implementation model that incorporates "top-down" and "bottom-up" elements of implementation research methods, including how to measure the effectiveness or outcomes of the implementation strategies used (Proctor et al. 2009) (see Fig. 46.1).

Proctor and colleagues model incorporate theories of dissemination (Torrey et al. 2001) and transportability (Addis 2002; Hohmann and Shear 2002), as well as implementation and diffusion of innovation (Rogers 2003). Their model describes a linear process to translating evidence-based practices into service delivery systems. The model presupposes three distinct types of translation outcomes—implementation, service,

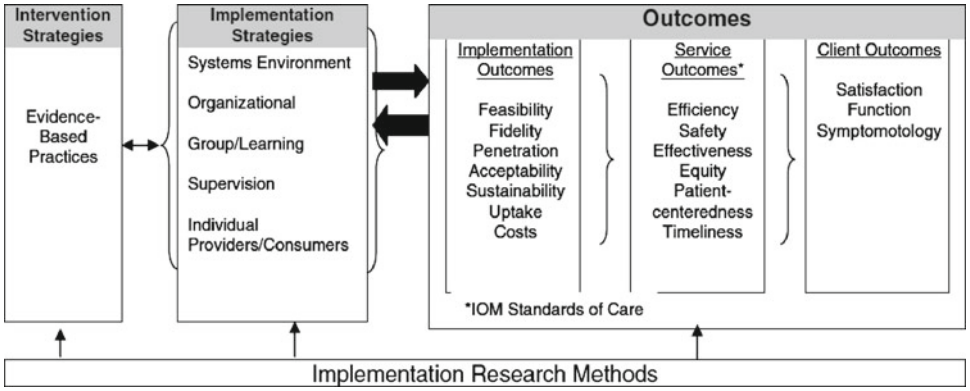

Fig. 46.1 Proctor and colleagues' conceptual model of translation research

Table 46.1 "6P" strategic framework for implementing evidence-based practices

Patient/consumer	Enhance self-management/participation Link with community resources Evaluate preferences and change behaviors
Providers	Improve knowledge/skills Provide decision support Link to specialty expertise and change behaviors
Practice/delivery systems	Establish chronic care model and reorganize practice Link with improved information systems Adapt to varying organizational contexts
Plans	Enhance monitoring capacity for quality/outliers Develop provider/system incentives Link with improved information systems
Purchasers (public/private)	Educate regarding importance/impact of mental illnesses on health Develop plan incentives/monitoring capacity Use quality/value measures in purchasing decisions
Populations and policies	Engage community stakeholders; adapt model to local needs Develop community capacities Increase demand for quality care enhance policy advocacy

and client outcomes. As a consequence of the three distinct types of outcomes, the model requires involvement of stakeholders at different levels within a system of care such as payers, clinical administrators, providers, and patients.

Another implementation model that is useful to conceptualize the issues that must be addressed to change practice is Pincus and colleagues "6P" model (Pincus et al. 2003) (see Table 46.1 for details).

Pincus and colleagues conceptualized the challenges to implementing the chronic care model for the treatment of depression in primary care settings as a strategic framework targeting six levels of the healthcare system. The six levels of the healthcare system are consumers, providers, practice/clinic, mental health plans, purchasers (public/private), and populations.

To illustrate the usefulness of these two models for implementing new interventions, we will apply them to implementing evidence-based interventions to reduce mental healthcare disparities.

Kilbourne and colleagues described a conceptual framework to advance our understanding of the barriers and strategies to overcome healthcare disparities (see Fig. 46.2) (Kilbourne et al. 2006).

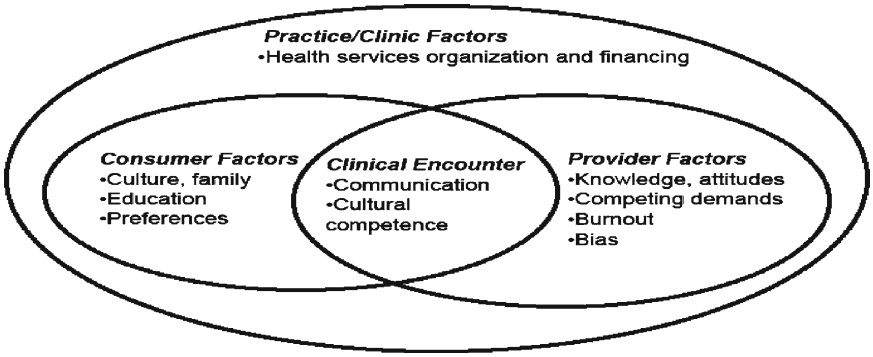

Fig. 46.2 Conceptual framework of factors involved in healthcare disparities

Their framework described several issues to be addressed at the consumer, provider, and practice/clinic levels of the mental healthcare system described in Pincus and colleagues "6P" strategic framework. At the practice/clinic level, certain organizational features either reduce or promote mental healthcare disparities. Some of the proposed organizational factors are insensitivity to cultural competence or health equity, few staff of nonmajority ethnic background, and a lack of available translation services.

From a financing perspective, how clinics are reimbursed for their services may be a disincentive to serve nonmajority populations.

At the consumer level, ethnic/cultural/familial explanations of mental illness (Kleinman et al. 1978) may limit access to mental health services. Limited knowledge and understanding about mental illness and the available treatments may also limit mental healthcare access. Additionally, the consumer's preferred type of care (Dwight-Johnson et al. 2000) as well as provider decision-making style (Leighl et al. 2001) have also been shown to influence patient retention in care.

Provider factors that influence care access and treatment decisions include: (1) providers' knowledge of and attitudes towards nonmajority individuals (Kleinman et al. 1978); (2) competing demands and time pressures, as well as burnout, reducing their sensitivity to cultural issues (van Ryn 2002; Ridley et al. 1994); (3) provider's own cultural biases influencing their communications with consumers; and (4) providers' competence and sensitivity towards consumers of different racial/ethnic persuasion than their own (Kleinman et al. 1978; van Ryn 2002).

Since we intend to improve nonmajority consumers' access to quality care and treatment outcomes, we would use the "6P" model to guide the development of interventions at multiple levels of the mental healthcare system. After we developed our intervention guided by the "6P" model, we would follow Proctor and colleagues model starting with intervention development. Initially, we would test our intervention in one usual care setting. Thereafter, we would test our intervention in other usual care settings. If our results supported the effectiveness of our intervention in reducing mental healthcare disparities in multiple settings, we would have identified what Proctor and colleagues call an evidence-based practice. Thereafter, we would move to developing an implementation strategy addressing the factors in Proctor and colleagues' implementation strategy box. For each factor, different strategies would be employed to ensure there was uptake of information about the new intervention, a plan to implement the new intervention, and well-validated measures would be chosen to assess outcomes of the implementation strategy.

Per Pincus and colleagues "6P" model, implementing this evidence-based practice would require changes in how payers incentivize the use of the intervention, service system administrators' acceptance and support for using the intervention, clinicians' behaviors in appointments

with nonmajority consumers, and (potentially) the duties, responsibilities, and behaviors of office support staff.

Pipeline Model

As you can see, implementing a new intervention is not simple and is probably one reason for the science to practice gap. The science to practice gap has been well recognized. Balas proposed that it takes 17 years to turn 14% of original research into patient care (Balas and Boren 2000). Balas described a model of how original research ultimately is translated into practice. He called his model the "pipeline" concept of disseminating research to get evidence-based practice. Green has suggested the "pipeline" model presupposes an empty vessel provider who is waiting for new knowledge. This new knowledge is somehow pushed through the pipeline and then poured into the waiting provider (Green 2008).

Green has proposed the "pipeline" model fails the provider for several reasons (Green 2008). First, 17% of all original research, including effectiveness research, has negative findings and is generally not reported. The information captured in these negative studies may be of particular interest to the provider for they may tell the provider how the intervention may not fit with certain consumers or conditions. In this case, the pipeline model for the dissemination of research findings into practice fails because the negative study findings were not used in the development of treatment guidelines.

The second failure of the "pipeline" model is the assumption that care providers are waiting for new knowledge. In reality, mental health organizations and providers typically react quickly to changes in mental health care financing and reimbursement, the political landscape that impacts the sustainability of any new intervention, and an ever increasing demand for a diverse array of services with no significant increase in the supply of providers. These contextual factors that administrators and providers confront on a regular basis are not taken into consideration in the "pipeline" model and therefore call into question the waiting provider assumption.

Another failure of the "pipeline" model is that the information funneled through the pipeline may not be relevant in a provider's particular service setting. Clinicians and administrators have questioned whether the evidence generated in research studies conducted elsewhere is applicable to their practice setting for their local circumstances may differ significantly from those in the research study (Armstrong 2002; Duan et al. 2002).

The failure of the "pipeline" model to consider the contextual factors of local settings have pushed researchers to rethink how they do business. Proposed approaches to improve the uptake of research knowledge in clinical settings are including providers and consumers in all phases of research; from question development to study design and testing. One inclusionary research approach that has increased the uptake of evidence-based practices in real-world settings is community-based participatory research (CBPR) (Israel et al. 2003).

Community-Based Participatory Research

CBPR approaches arose as a solution to the problems inherent in the pipeline model of treatment development and dissemination. In addition, the push for more participant involvement in research decisions has come from healthcare payers, policy makers, and nonmajority communities. Healthcare payers have called for research that is collaborative and community-based, rather than community-placed. Policymakers and nonmajority communities have called for research aimed at eliminating health disparities (Bruce and Uranga McKane 2000; George et al. 1998; Israel et al. 1998).

CBPR is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings (Definition of CBPR Community Health Scholars Program 2001). CBPR would be considered a "bottom up" approach to applied research in that both researchers and community

members collaboratively share in the development of the questions asked, the methods employed to address the question, the interventions developed, and the kinds of outcomes desired, valued, and measured (Gaventa 1993).

Although CBPR is often referred to as a research method, CBPR is actually an orientation to research. Cornwall and Jewkes (1995) described the distinctiveness of the CBPR approach as the methodological contexts of their application. What is new is not the use of unique research methods or study designs. Rather, the uniqueness lies in the attitudes of the researchers, which in turn determines how research is conceptualized and conducted. The location of power and control over the research process is another distinctive factor. CBPR empowers research participants to be more than research objects. In addition to informed consent or letters of support for research, participants give their knowledge and experience to the formulation of research questions and to many other aspects of the research process. As a consequence of this change in location of power and control over the research process, CBPR strengthens the awareness of research participants' own capabilities as researchers and agents of change (Hagey 1997).

The fundamental characteristics of the CBPR approach are (Israel et al. 1998):

- It is participatory
- It is cooperative, engaging community members and researchers in a joint process in which both contribute equally
- It is a colearning process in that both researchers and community members learn from one another
- It involves systems development and local community capacity building
- It is an empowering process through which participants can increase control over their lives
- It achieves a balance between research and action

For community psychiatrists, CBPR affords an orientation to research that allows for their direct involvement in the research process as well as the development and tailoring of research interventions that take into consideration the unique features of the setting they work within.

Summary

Unlike other psychiatric subspecialties, community psychiatry embraces the complexity of mental health service systems and organizations and their impact on how treatment must be altered or changed to improve the quality, cost, and outcomes of care. In addition, community psychiatry focuses attention on community-based factors that impede consumers' access to care and the outcomes from the care they provide. We seek to employ evidence-based practices that are implementable, sustainable, and aid consumers in their recovery in real-world settings. To achieve these goals, community psychiatrists must have a sound appreciation of mental health services research methods, the strengths and weaknesses of interventions developed in the traditional pipeline research strategy, and the contextual factors that influence the dissemination, implementation, and sustainability of traditionally developed evidence-based research interventions. To provide services that are valuable to consumers' recovery, we must be involved in all aspects of intervention development; from the questions addressed, the methods used, and the analysis, interpretation, and application of study findings. Nontraditional approaches to research such as CBPR provide a roadmap to how we can be more active and less passive in the creation of the interventions we employ.

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Part IX

Shaping the Future: Education, Workforce, and Professional Development

47 Medical School and Residency Education in Community Psychiatry

Kathleen A. Clegg

The Need for More Clinicians and Enhanced Education in Community Psychiatry

There is broad agreement that there is a shortage of well-trained, committed psychiatrists working in the public sector. Many would agree that the quality of education and training for professionals in this sector significantly influences the quality and quantity of psychiatrists choosing to practice in publicly funded settings. Therefore, this chapter will focus on medical student and resident education in community psychiatry and what can be done to enhance the effectiveness and attractiveness of professional preparation for careers in this field.

As we shall see, two aspects of medical school curricula and placements offer significant opportunities for enhancement. First, while a good deal about advances in the neurosciences and biologic treatment has been incorporated into medical school and psychiatry residency curricula, relatively little is typically presented in medical school and in psychiatry residency programs on the critical issues affecting community/public sector psychiatrists. Second, most medical student clerkship placements and most psychiatry residency placements are in hospital settings, despite the fact that the vast majority of persons living with mental illness are living and receiving mental health services in the communities in which they live.

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Community Psychiatry in Medical Schools

Medical schools vary greatly in the amount of the curricula dedicated to psychiatry in general and to community psychiatry, in particular. For example, in the first year of medical school, many schools offer a course that teaches the basics of "behavioral science" and includes topics such as the doctor–patient relationship, the clinical interview, ethical issues facing physicians today, as well as many of the cultural and societal issues that patients face. Some schools involve psychiatrists in these first-year courses, but many schools rely almost entirely on primary care faculty practicing in areas such as family medicine and internal medicine to perform this function.

From the perspective of psychiatry, it would be better to include more psychiatry faculty, including community psychiatry faculty, in the teaching teams for these first-year courses. Medical students could be exposed to general psychiatrists and community psychiatrists earlier in their education and this would likely have a positive impact on career choice. Moreover, it would strengthen these courses for all medical students to include more psychiatrists because

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psychiatrists in general, and community psychiatrists in particular, tend by necessity to be expert in the behavioral science dimensions of key issues typically addressed in these first-year courses, such as doctor–patient communications, working as part of an interdisciplinary healthcare team and working with individuals from disenfranchised groups.

Research studies have been done that examined topics covered in these early behavioral science courses. Though there is surprisingly little consensus on the topics taught in these courses, a discernable trend during this period (1983–2004) is that less time was being devoted to psychodynamic theory and more time is devoted to the neurobiology of behavior (Manley and Trachenberg 1999; Arnett and Hogan 1983; Manley 1994; Signorelli et al. 2004).

Clearly, guidance to medical schools from authoritative bodies urges greater attention to behavioral science topics. Not surprisingly, considering the source, in 1994, the committee on Medical Student Education of the American Psychiatric Association strongly recommended that a number of behavioral science topics be addressed in the curricula of all medical schools. Several of the topics that group identified are routinely addressed in the practice of community psychiatry, most notably cultural influences on health and health-related behaviors, health and illness in social context, domestic violence, suicidal and homicidal behavior, alcoholism, and substance abuse.

Similarly, topics that are particularly important in community psychiatry, such as adherence, cultural issues affecting the medical interview, the organization and cost of medical care, and emotional and behavioral factors affecting disease treatment and prevention, such as substance abuse, can already be found in the content description of the behavioral science component of the United States Medical Licensing Examination (USMLE) (USMLE 2004).

In the second year of medical school, most schools have a course covering psychopathology, as well as basic psychopharmacology. In many medical schools, this course may be the first time a medical student has been exposed to a psychiatrist. Historically, there has been greater consensus about what topics should be covered in this course. However, despite this history, a growing number of medical schools are combining the second-year psychopathology course with a neuroscience course, reducing the time available to address these important behavioral science topics. And once again, since community psychiatrists are underrepresented in most academic medical centers (McQuistion et al. 2004), a community psychiatrist seldom teaches such courses.

In the third year of medical school, students are required to complete a series of core clerkships in a number of areas of medicine, specifically Internal Medicine, Surgery, Pediatrics, Obstetrics/Gynecology and Psychiatry in order to be accredited (Liaison Committee on Medical Education 2003).

The importance of the clerkship experience cannot be overemphasized, as the clerkship experience has been shown to be a critical factor in medical students' career choices (Clardy et al. 2000). Most medical students do not go on to pursue careers in psychiatry, though the psychiatry clerkship is the point in their clinical education where all medical students learn about the clinical care of persons with psychiatric diagnoses that clinicians in every field of medicine encounter. There are issues with the duration and nature of this clerkship in American medical schools that require updating.

No governing or regulatory body mandates the amount of time spent on each clerkship experience, but psychiatry clerkships tend to be shorter than clerkships in other fields (Rosenthal et al. 2005). The length of psychiatry clerkships generally ranges from 3 to 8 weeks with a mean of approximately 6 weeks (Rosenthal et al. 2005). In our view, this is particularly unfortunate in that every practicing physician encounters an increasing number of patients with psychiatric disorders, as the prevalence of such disorders is steadily increasing (Rosenthal et al. 2005).

In addition, the practice of combining psychiatry and neurology in the preclinical curriculum has also worked its way into the clinical curriculum. Here, the psychiatry and neurology clerkships are frequently combined. This has been done in many schools in order to respond to shortened clerkship lengths, as opposed to necessarily

addressing overlap between the clinical practices of psychiatry and of neurology. Many schools that have attempted such integration have ended up with courses and/or clerkships that are juxtaposed in the curriculum, but not truly integrated. For instance in an 8-week neuropsychiatry clerkship, frequently the clerkship experience is divided as 4 weeks of neurology and 4 weeks of psychiatry, rather than 8 weeks of a truly integrated experience.

Perhaps even more problematic is a trend of "merging" many psychiatry clerkships with still other medical specialties such as family medicine. While there is merit to collaborative teaching and learning, and in training future physicians in integrated care (Collins et al. 2010), merging psychiatry clerkships with other clerkships risks psychiatry being marginalized and with the psychiatry portion being further shortened.

Increasing numbers of persons with psychiatric disorders are treated in community and other outpatient settings and, in fact, the bulk of general psychiatric practice occurs in outpatient environments. Nevertheless, many schools offer insufficient basic clerkship time in outpatient environments, with still fewer offering exposure to community mental health or other public sector psychiatry settings. Most psychiatry clerkships are conducted in inpatient settings, despite increasingly shorter lengths of stay that focus on acute stabilization rather than full symptom remission. This leads to medical students not learning sufficiently about the "real world" practice of psychiatry. One way to alter this situation is for psychiatry departments to appoint community psychiatrists as clerkship directors, with explicit encouragement to establish community mental health placements that better represent modal psychiatric practice.

Finally, in the fourth year of medical school, students have the opportunity to take electives in order to explore areas in which they might like to further their learning and education. For some students, the fourth year and these electives may be the first opportunity to investigate community psychiatry as a career option.

However, it can be argued that, in many ways, this point in the curriculum may be "too late" to influence substantially a student's career choice, as students are already beginning to interview for residency positions in the first few months of their fourth year of medical school. Another trend further reduces the career exploration value of fourth-year electives. That is, in our experience, medical students use several of these fourth-year electives solely as "audition" months in which they pursue electives in a chosen field at a number of different sites in order to enhance their chances of matching in a residency program at one of these sites. In the current climate, one inroad may be more proactive advising regarding a well-rounded fourth year.

Still, many medical schools do continue to offer electives in a number of subspecialty fields of psychiatry, such as child psychiatry, forensic psychiatry, psychosomatic medicine or consult-liaison psychiatry, geropsychiatry, and community psychiatry. In those programs where an elective in community psychiatry is offered, it may include exposure to a unique population such as people with mentally illness and homelessness, or those living with HIV/AIDS. And students may be exposed to various treatment settings and modalities such as those offered by mobile crisis teams, crisis shelters, clubhouse models, and drop in centers.

The preceding discussion of community psychiatry topics and the role of community psychiatry faculty in undergraduate medical education might justifiably be viewed as the enumeration of a distressing set of negative trends. However, each area of concern can also be viewed as identifying a strategic pressure point, that is, an opportunity that can be utilized by resourceful psychiatry and especially community psychiatry faculty to improve medical education and encourage more students to enter psychiatry.

Folding Community Psychiatry into the Psychiatry Residency Curriculum

Psychiatry residencies are governed by the rules of the American Council on Graduate Medical Education (ACGME) and the Residency Review Committee, which define competencies that must be achieved by psychiatry residents in the course of the 4 years of their training. These governing

bodies are moving away from dictating the amount of time a resident must spend in various treatment settings and toward a more competency-based approach to residency education.

This new approach focuses on a resident's performance and the demonstration of learning outcomes. The goal of this shift is to help residents develop greater competence as a physician and to improve the quality of the patient care they are actually able to deliver. The six competencies identified by the ACGME include the following broad themes: Medical Knowledge, Patient Care, Interpersonal and Communication Skills, Professionalism, Systems-Based Practice, and Practice-Based Learning And Improvement (ACGME 2012).

This competency-based approach actually makes it easier to think about creative ways to fold community psychiatry into curricula offered to all residents by a department of psychiatry. Working with clients in a community psychiatry setting requires an especially broad set of interpersonal and clinical skills. It is thus an ideal setting to learn and acquire these competencies. And community psychiatry settings tend to provide especially accessible training site opportunities for both medical students and residents because the assistance they provide tends to be more highly valued in these settings than in other outpatient settings.

Further, one of the six prescribed competency areas, systems-based practice, can be one of the more difficult areas to address. Community psychiatry is quintessentially systems-based. Its practice settings, which are typically multidisciplinary and team-based in approach to service delivery, are especially appropriate to the development of competence in systems-based practice.

Admittedly, folding extended, comprehensive community psychiatry training into the training of all psychiatry residents may sound like a radical proposal. The following is an illustration of the advantages of this approach, but first, a brief history of training in community psychiatry.

In the early 1960s, most community psychiatrists were trained in state hospitals, and university-based training programs were just developing. After the Community Mental Health Centers Construction Act in October, 1963, mental health care began the transition from state hospitals to the community, and many community psychiatrists made this transition along with their patients.

By the late 1960s and early 1970s, the transformation of the base of training from the state hospital to the university hospital was well under way, with patchy efforts across the country, such as a pioneering community psychiatry program at Albert Einstein College of medicine in the Bronx (McQuistion and Rosenheck 2006). Owing to the "Mental Health Systems Act" in 1980, which was a result of the second presidential commission to study the mental health system in the US, the National Institute of Mental Health began to fund statewide community support grants to recognize state mental health programs and to train core mental health disciplines to improve the community support service systems in the states. Very quickly, training grants followed for psychiatry residency programs. In 1979, Shore, Kinzie, and Bloom published an article describing required educational objectives in community psychiatry (Shore et al. 1979). In 1981, Cutler et al. describe an Oregon Health Sciences University program where residents received training in working with community support systems for chronically mentally ill persons (Cutler et al. 1981). In 1988, a model community psychiatry curriculum for psychiatry residents in Wisconsin was also described (Factor et al. 1988). In 1991, states and universities began to collaborate in the training of psychiatrists to work in the public sector, both hospital and community (Talbott et al. 1991). This model of public-academic collaboration continues to the present time. We will now describe a successful model of this type of public-academic collaboration at Case Western Reserve University (CWRU) in Cleveland, Ohio.

Community Psychiatry at Case Western Reserve University

CWRU has a comprehensive model of training in community psychiatry that may be useful for readers to draw upon. The residency training program in psychiatry at the University Hospitals Case Medical Center (UHCMC) WRU

incorporates community psychiatry as a major component during the second half of the residency program for all residents. The first 2 years of residency include the required inpatient psychiatry experiences as well as a rotation in psychosomatic medicine/consult-liaison psychiatry.

The community psychiatry experience, during the third and fourth years, takes advantage of the existence of a community-based educational program in community psychiatry that has been in operation for the past 20 years, the Public Academic Liaison Program (PAL). PAL is a collaboration between the University Hospitals Case Medical Center Department of Psychiatry and the Alcohol, Drug and Mental Health Services (ADAMHS) Board of Cuyahoga County, Ohio, in Metropolitan Cleveland. It provides clinical and training opportunities for psychiatry residents and medical students, supervised by full and part-time faculty—most of whom also provide clinical services, throughout Cuyahoga County. The University and ADAMHS both consider this program to be an excellent and valued example of responsible community service on the part of the CWRU School of Medicine and University Hospitals of Cleveland.

Initially, the PAL Program involved a limited number of general psychiatry residents and faculty, but it quickly grew to include all general and child psychiatry residents. The [ADAMHS] Board administers 37 different community agencies ranging from small specialty programs in housing, vocational rehabilitation, and homeless and crisis services to large "case management" or "community support service" agencies. Over the past 20 years, PAL has provided more than 90,000 clinical hours to these agencies, and, notably, PAL graduates now comprise a majority of psychiatric providers within this system.

PAL residents, clinical faculty, and full-time faculty provide psychiatric services at seven of the larger ADAMHS-associated agencies. Clinical faculty and residents also collaborate in the provision of regular in-service trainings for agency staff. In addition, a long-standing Community Case Conference series is held monthly at one or another of the participating agencies.

Biannually, the C-UH Department of Psychiatry also hosts the "All Ohio Institute on Community Psychiatry," a statewide celebration of community mental health services. It draws more than 450 multidisciplinary participants from around the state. This major meeting offers large group plenary and lectures sessions, and a number of small group workshops, showcases, and poster presentations focused on current clinical, political, and financial issues that challenge community mental health service providers throughout Ohio. This meeting provides a major opportunity for community-based practitioners from around Ohio to share their innovations. They do so in a continuing education activity that also showcases the latest thinking and innovations of experts at the state's medical schools, teaching hospitals, and local and state government agencies. A number of national community psychiatry experts are also invited with a convenient to participate. This conference provides trainees regional forum in which to present workshops and showcase presentations or posters. They also have the opportunity to network with academic community psychiatry faculty as well as psychiatrists practicing in public settings in the community.

Structure and Operation of the Community Psychiatry Curriculum

Utilizing ACGME's competency themes of Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-based Practice, in the following sections we describe the goals and objectives of the community psychiatry curriculum embedded in this 2-year experience and how they are integrated with residents' clinical responsibilities. Boxes 1 and 2 outline these goals and objectives. Learning objectives are divided by core competency and further subdivided by postgraduate year, beginning in the PGY 3 year, when residents first enter the community mental health center setting. PGY 3 goals and objectives continue into the fourth year of training with a "layering on" of additional skills, responsibilities, and independence of clinical practice. Additionally, PGY 4 residents are expected to function as "senior residents," participating in the training and education of the junior residents and medical students.

Box 1 PGY 3 Goals in Community Psychiatry

Patient care
- Exhibit appropriate knowledge of the patient.
- Gather not only a past psychiatric history, but also past experience with the mental health system.
- Gather information from a variety of sources: e.g., records, family members, case managers, outside agency records.
- Generate an appropriate differential diagnosis.
- Develop and present biopsychosocially informed formulations.
- Demonstrate sound therapeutic decision-making skills and implement appropriate treatment plans.
- Work with a team of professionals, as well as patient families and supports to implement treatment plans.
- Monitor for treatment response and adjust the treatment plan according to the needs of each individual patient.
- Perform indicated basic health maintenance screening.
- Identify when the need exists to refer patients for medical or surgical care.
- Counsel and educate patients with regard to diagnosis and recommended treatment.

Medical knowledge
- Demonstrate knowledge of the major mental health disorders, as well as common comorbid medical diagnoses.
- Demonstrate a working knowledge of psychopharmacology, including measures to address adherence issues.
- Understand the complexities of working with patients with substance use disorders/dually diagnosed patients.
- Demonstrate knowledge of indicated laboratory monitoring because of the use of psychiatric medications.
- Demonstrate knowledge of the variety of treatments available in the community setting.
- Actively pursue independent learning and apply current medical-based knowledge and best evidence-based community practices to foster recovery.

Practice-based learning and improvement
- Integrate feedback in order to improve patient care.
- Identify areas for performance, process and systems improvement.
- Outline a plan for implementation of a performance improvement project.
- Attend presentations and meetings with a focus on practice-based learning and improvement.

Interpersonal and communication skills
- Create and sustain therapeutic and ethically sound relationships with patients.
- Maintain appropriate boundaries.
- Gather collateral information.
- Elicit and communicate information using a range of communication skills.
- Demonstrate cultural competence.
- Work effectively within a systems-based, recovery-oriented, and patient-centered practice managed through a diverse treatment team.

Professionalism
- Meet universal standards of professionalism working effectively with all members of the treatment team.
- Show respect for patients at all times.
- Ensure that patient autonomy is respected through the process of informed consent.

Systems-based practice
- Develop a working understanding of how the practice of psychiatry and its delivery are influenced by healthcare organizations.
- Become knowledgeable about the resources available to patients and help patients access those resources.
- Demonstrate understanding of the importance of advocacy for quality mental health care.

Box 2 PGY 4 Goals in Community Psychiatry

Patient care
- Meet the objectives of the PGY 3 in the community setting independently, seeking supervision as appropriate.

Medical knowledge
- Plan and implement in-service sessions for community mental health center staff, psychiatry residents, and medical students.

Practice-based learning and improvement
- Identify an area for improvement in the clinical setting and plan and implement a performance improvement project.

Interpersonal and communication skills
- Continue to engage in therapeutic and ethically sound relationships with patients and function effectively as part of the interdisciplinary team.

Professionalism
- Continue to demonstrate professional behaviors with patients, families, staff, peers, and supervisors and serve as a role model for PGY 3 residents starting in the community mental health center setting.

Systems-based practice
- Identify, plan, and implement an advocacy effort.

Patient Care

In the Case Western University—University Hospitals Psychiatric Residency Program, residents typically follow a caseload of 20–40 clients, in 1 of 6 community mental health center settings. Their caseload is monitored and controlled for volume and variety of experience. Residents perform psychiatric diagnostic evaluations and provide ongoing care for their caseload of patients. Supervision is provided on-site by experienced, board-certified faculty, who see the patient immediately following the resident evaluation and periodically thereafter, "as needed." Residents have the opportunity to work with a multidisciplinary team including psychologists, psychiatric nurses, social workers, counselors, vocational counselors, and community support service providers (case managers), and are considered a part of the team. The central role of the interdisciplinary team in community mental health settings is emphasized.

A community psychiatry didactic seminar is held in the PGY-3 year. And residents attend the monthly community case conferences held at the agencies on a rotating basis, where discussants are full-time clinical faculty.

Most people seen by psychiatry residents are receiving case management services for serious and persistent mental disorders and many receive other services as well, such as counseling, housing support, vocational, and crisis services. Residents primarily participate in diagnostic assessment and medication management and develop comprehensive biopsychosocial treatment plans in collaboration with the other members of the community treatment team (psychiatrist, psychotherapist, psychiatric nurse, and social worker). They may perform disability evaluations and other specialized assessments under supervision and also have experiences in crisis intervention, partial hospitalization programming, group therapy, and supportive psychotherapy. Leadership and educational experiences accrue from their involvement in the multidisciplinary team. Optional experiences include emergency psychiatry, outreach crisis intervention, and experience with specific groups with substance use and other disorders.

Clinical placements include a variety of community mental health center settings, and residents have the opportunity to voice preferences based on the services provided at the various agencies. These agencies primarily serve individuals diagnosed with severe psychiatric disorders. The demographic of the patient population served by individual agencies reflects the demographics of the geographic area in which the agency is located. Some agencies serve more Latino clients and others primarily African-American clients, allowing residents the opportunity to develop cultural competence in practice.

Some agencies provide primarily medication management and case management services, other agencies have counseling programs available as well. Clients with co-occurring mental illness and substance use disorders "are the rule not the exception." A few of the agencies have special treatment tracks for such issues.

One agency provides services to the mentally ill homeless population. Its services include a homeless outreach team, which is a popular rotation among residents and medical students. The agency is also the home of the Adult and Child Mobile Crisis Teams for the county, providing crisis services to any person experiencing a mental health crisis. Another agency has programs for special populations such as those living with HIV/AIDS, older adults, individuals with homelessness, women and families, and prison reentry, and criminal justice offenders with mental disorders.

The residents are also exposed to issues related to psychiatric administration as the medical directors at some of the participating agencies are former PAL residents, and now full time or clinical faculty members. These mentorship experiences serve to better prepare residents to take leadership positions in community mental health settings and in other healthcare settings upon completion of their residency training. There are also community-based organizations that serve children and families in which general psychiatry residents, as well as child psychiatry fellows, have clinical placements. The client populations at these agencies include children with behavioral problems, symptoms consistent with ADHD, symptoms resulting from sexual and/or physical abuse, depressive disorders, or suicidality. One of these organizations is school-based, offering residents and fellows opportunity to provide community mental health services in the school setting.

Residents have a number of options for shorter elective experiences, as well. Two elective opportunities are in college mental health/counseling centers where residents learn to apply the principles of community psychiatry to persons in the college community. There is an opportunity to see clients at a free medical clinic, serving uninsured or underinsured individuals. Popular electives include the homeless outreach team where residents perform outreach activities in the community as part of a dedicated multidisciplinary team. This unique rotation offers residents the opportunity to deliver service to individuals struggling with mental illness that either refuse to or are physically unable to engage in traditional services, thus meeting the service needs for patients most at risk of falling through the cracks in the system.

Medical Knowledge

The second core competency, Medical Knowledge, is met through the didactic and case conference curriculum, which spans the 4 years of psychiatry residency. The didactic curriculum in medical knowledge by level of training in areas that are particularly important for Community Psychiatry is as follows:

In the PGY 1 year, there are courses in addiction psychiatry and concerning advocacy for patients with mental illness, with support from the National Alliance on Mental Illness. When residents enter their second year, the curriculum reflects important issues in schizophrenia, including its neurochemistry/neuropathology, its neuroimaging features, its diagnosis and treatment, the risks and benefits of antipsychotic medication, its psychosocial interventions, research directions, along with a didactic introduction to community-based care.

To complement their community-based clinical experiences, there are specific PGY 3 didactic offerings. They comprise of the following components.

Community case conference: Each resident is assigned a date to present one of his/her patients to a guest faculty discussant. Also in attendance at the conference are the rest of the PGY 3 and 4 psychiatry residents and members of the interdisciplinary team at that agency, including staff psychiatrists, nurses, case managers, and counselors. After the presentation, the patient is interviewed

by the discussant in the conference, followed by a discussion of the case, including its diagnostic and treatment issues. Particular attention is paid to the unique characteristics of community mental health center setting, including the limitation of available resources.

Addiction/substance use disorders: This series covers American Society of Addiction Medicine patient placement criteria and levels of care, integrated dual diagnosis treatment, smoking cessation tools for psychiatrists, relapse prevention training, motivational interviewing, and interface between pain and addiction.

Public and community psychiatry: This is a series of presentations covering: History of Public and Community Psychiatry; Systems-Based Practice; Entitlements; Recovery and Illness Management; Evidence-Based Practices (two parts—including pharmacologic management, Assertive Community Treatment, Family Psychoeducation, Supported Employment); Role of Psychiatrist working collaboratively in the Community Mental Health Center setting; Housing and Homelessness; Mental Health Policy; Criminal Justice and Community Mental Health; Trauma and Trauma Informed Care.

Forensic psychiatry: This series covers: Basic Law for Psychiatry Residents; Confidentiality, Privilege and Duty to Protect; Psychiatric Malpractice; Malingered Mental Illness; The Many Faces of Competence; Right to Psychiatric Treatment and Right to Refuse Treatment; Civil Commitment; Competence to Stand Trial; and the Insanity Defense.

Advocacy: Addresses issues of advocacy for patients with mental illness including an introduction to the National Alliance for the Mentally Ill (NAMI).

Practice-Based Learning and Improvement

In the community mental health center setting, residents systematically analyze practice performance to identify opportunities for improvement, develop an improvement plan, implement and monitor the plan, and incorporate changes that result in improvement into practice in sustained ways. The resident develops the ability to learn from and continuously apply what is learned from these activities.

Interpersonal and Communication Skills

The multicultural diverse populations served in the community mental health centers give residents opportunity to employ interpersonal and communication skills, the fourth core competency. They create and maintain therapeutic and ethically sound relationships with patients in settings that include multimodal diagnosis, multicultural diversity, and lower social-economic privileges. They learn to maintain appropriate boundaries in the therapeutic relationship while appreciating therapeutic flexibility within the limited resources that are prevalent in lower-income community settings. They learn the awareness, ability, and benefit of gathering collateral information to refine diagnosis and treatment planning. They gain ability to thoroughly elicit and clearly communicate information using a range of communication skills, including nonverbal, effective listening, explanatory, questioning, and writing skills, all within the context of a diverse cultural, social, and educational milieu. They learn to understand the wealth of benefits of having the ability to communicate with patients in a culturally sensitive manner. They learn to work effectively within the context of a system-based, recovery-oriented, and patient-centered practice managed through a diverse treatment team of supervisors, physicians, case managers, nurses, and office staff.

Professionalism

The sensitivity and integrity necessary to meet the many demands of working in a community mental health center setting allows residents ample opportunity to continue to refine their skills in the area of professionalism. They continue to be required to meet universal standards of professionalism including promptness, appropriate appearance and demeanor, and responsibility in supervision (planning, arriving on time, reading

recommended materials, being open to feedback, and utilizing feedback in future patient care).

They learn to work effectively with all members of the treatment team, respecting office staff, nurses, therapists, and case managers as all having a critical role in patient care. They practice demonstrating the value of respect for clients at all times and help maintain the dignity of patients who are often demoralized by poverty and stigmatizing past histories such as substance abuse histories and/or legal system involvement. They continue to balance respect for patient confidentiality with responsibilities to report on progress to third parties such as probation officers or child welfare officials.

Systems-Based Practice

Residents develop a working understanding of how the practice of psychiatry and its delivery are influenced by healthcare organizations as well as community bias with regard to mental health care. They learn to serve as the coordinator of care, since many times a community mental health center is the only place patients have to receive any kind of healthcare services. The patients served in the community mental health centers may lack health insurance; many are covered by Medicaid or Medicare, so implementing a risk/benefit analysis with regard to cost is essential. Residents participate in team meetings where they advocate for quality patient care in settings that will best insure the patient's safety, meet the mental and physical health care needs of the patient, and advocate for access to social services that will enhance optimal quality of life for their patients.

They become knowledgeable about resources available in the community such as food pantries, shelters, primary care clinics, clothing donations sites and help clients access those resources. Additionally, residents must regularly consider how to best distribute resources within the community mental health system, particularly when considering the limited availability and funding for high cost services and medications weighed against the clinical severity of symptomatology for their patients; such risk-benefit analyses are often at the center of the care they deliver. Residents have the benefit of on-site supervision by full time or clinical faculty as they implement these elements of systems-based practice. Some residents have chosen an "Advocacy Elective" that focuses on approaching advocating for mental health care at the broader level, by involvement with professional organizations, legislative activities, courts, etc. to raise awareness and educate others about inequities and stigma regarding mental health treatments and patients receiving psychiatric treatment.

Future Directions in Medical Student/Resident Education in Community Psychiatry

Having reviewed the current state of medical school and psychiatry residency training in community psychiatry, we now explore future directions.

Ideally, medical students ought to be introduced early in training to the field of community psychiatry and the social issues affecting the provision of health care, including mental health care. Psychiatrists, and in particular community psychiatrists, should be part of the teaching faculty in the coursework in the "Foundations of Medicine," sometimes referred to as the Doctoring course, or Doctor-Patient Relationship course, that typically occurs in the first year. Community psychiatrists should also be part of faculty teaching the second-year medical school course on Human Behavior and Psychopathology or its equivalent. Community psychiatrists and exposure to community psychiatry should be integral to the third-year clerkship experience. Community psychiatrists have expertise in a number of areas important for the education of medical students, such as working as a member of an interdisciplinary team and addressing the needs of individuals with serious and persistent mental illnesses with limited resources in the context of the family and community. Students should have competent and passionate supervisors in their community psychiatry experiences during the clerkship, which, as noted, has evidence of being the biggest predictor of which field a medical student decides to pursue for residency (Signorelli et al. 2004).

As for psychiatry residency training, residents should graduate from residency prepared to provide clinical care in community psychiatry settings, having been educated about challenges facing people with serious and persistent mental illnesses and the evidence-based/promising practices used in treatment. Residents should be well versed in the recovery-oriented services (see Chap. 7 for a detailed discussion) and be able to work closely and supportively with people to attain their goals beyond merely helping them manage the symptoms of psychiatric illness. Residents should have access to quality on-site supervision during their community psychiatry rotations by a faculty member who is passionate about being a community psychiatrist and with expertise working in public and community settings. Residents should also have exposure to different settings in the community and be exposed to a diversity of faculty in order to get a broad view of community psychiatry as a career choice. Faculty should seek to retain residents to take positions in local community mental health centers after graduation and encourage them to go on to supervise residents themselves in order to develop a steady supply of quality supervisors for the perpetuation of the program. This would lay groundwork for some, who would continue in community psychiatry fellowships (discussed in Chap. 48), that would aim to educate graduates to develop the ability to assume leadership positions in community psychiatry, as well as participate in research that furthers the knowledge base in community psychiatry.

Issues for Further Study

Finally, there are a number of pressing issues regarding the future of education and training in community psychiatry. They deserve considerable discussion, systematic research, and innovative experimentation. Here are three that we view as most important.

Public and community psychiatrists will be called upon increasingly to function in a consultative and/or educational role with primary care providers, as less funding is available for dedicated community mental health centers and they are less able to meet the steadily growing psychiatric needs of their communities. This will require psychiatry residencies to include theory and practice regarding adult education principles. The ability to collaborate with professionals across disciplines will increase in importance.

Public and community psychiatrists will be called upon to be in the forefront of disaster mental health services, given the significant prevalence of immediate and long-term mental health sequelae resulting from such events.

Now that we are coming to appreciate that one of the primary long-term public health impacts of natural and man-made disasters concerns mental health, community psychiatrists likely will be called upon to assume significant leadership roles on disaster response teams as an expression of their larger commitment to public health and preventative mental health. Community psychiatrists may be asked to devote a greater proportion of their time in the immediate aftermath of disasters, using their crisis intervention skills to help large numbers of individuals and families to effectively utilize a diverse array of existing supports in the community in order to better cope with the residue of traumatic experiences. When the symptomatology of psychiatric disorders is identified during the acute phase of disasters, community psychiatrists will be asked to play a lead role in mental health triage and treatment, taking good advantage of their experience with the availability of limited resources. Community psychiatrists will be called upon to educate first responders and healthcare providers about the concepts of compassion fatigue and vicarious trauma, which are significant mental health concerns following disasters. Therefore, training in disaster mental health services must be incorporated into psychiatry residency training curricula.

Finally, the future, community psychiatry may be practiced in the context of the "medical home." Community mental health centers may become a medical home for growing numbers within the seriously mentally ill population. The composition of the interdisciplinary mental health team may need to be expanded to include primary care and the challenges of this medical home

responsibility may mean that community psychiatrists, themselves, will need to be better trained to recognize early signs of medical illness and develop even better skills for communicating with medical providers.

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48 Public/Community Psychiatry Fellowships

Jules M. Ranz

Introduction

Psychiatrists are popularly viewed as seeing patients in a private office practice setting. However, a 2006 survey of APA members demonstrated that early and midcareer psychiatrists now spend more time in publicly funded organizational settings than in private practice. Nonetheless, psychiatric training is still oriented toward careers in private practice, with little dedicated training for psychiatrists to work in organizational settings (Ranz et al. 2006).

Public funds comprised 58% of all mental health services in the USA as of 2006 (SAMHSA 2010, Table III.3). These government funds support myriad services in countless nonprofit and even private for-profit organizations. These organizations have mandates to use their public funding to serve the poor and other patients with severe mental illness and other disabling behavioral conditions. Public money appropriately comes with strings attached, such as contracts for specific services to mandated target populations, certification and accreditation standards, and mechanisms of fiscal accountability. Psychiatrists running and working in these organizations need to know what kinds of services will best fulfill the mandates that justify these public expenditures, how to create and maintain organizations to deliver these services, and how to deal with the myriad requirements incumbent upon functioning with public funds (for more detailed discussion of the Role of the Medical Director, see Chap. 44).

History of Public and Community Psychiatry Fellowships

The landmark 1963 Federal Community Mental Health Centers Act listed "mental health consultation" as one of five basic services to be provided by all community mental health centers. As a result, there was a marked development of training programs in this method in the mid-1960s (Caplan 1970; Cutler et al. 1996; Education for Community Psychiatry 1967).

Some of the earliest fellowship programs called themselves community psychiatry training programs, and others used the term social and community psychiatry, emphasizing the blending of the concepts of Social Psychiatry with the practices of Community Psychiatry. Thus, a program at the Albert Einstein College of Medicine in the Bronx, NY, used the term social and community psychiatry, "to train psychiatrists in the techniques of practice involved in community psychiatry and to teach the core content pertaining to social and cultural factors that promote mental health or produce mental illness, which

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comprises social psychiatry" (Pattison 1972). In addition, two of these early programs used the term Public Health to describe their programs.

None of these early programs survived more than a decade. A public psychiatry fellowship (PPF) training program was created in 1981 at Columbia (Ranz et al. 1996) and continues to date. No other current program has been in existence for more than 10 years, but programs at Emory and Case Western have been running for a decade, and 12 other programs have been created in the past 5 years. Probably influenced by the Columbia program's longevity and success, seven of these new programs use the term public psychiatry to describe their programs, one uses public service psychiatry and two use public and community psychiatry. Four programs use the term community psychiatry. One program is called an interprofessional fellowship on psychosocial rehabilitation and recovery oriented services.

In the 1960s, the term "community" generally referred to community outreach. Currently it refers to psychiatrists working in the community. Note, however, that one third of members of the American Association of Community Psychiatrists (AACP) work in hospital settings (Ranz et al. 2000). The term "community" also conveys a commitment to the community of patients being served, and by extension, the community of patients and providers. On the other hand, the term public conveys the practice of working in municipal, state and federal organizational settings. However, as above, the term public has also been extended to include publicly funded nonprofit organizational settings, which encompasses the majority of psychiatric care delivered in organization settings. Finally, the term public conveys a responsibility to provide care to public sector patients: The poor (especially single parent families, the elderly and children), and adults with severe mental illness, substance abuse or both. There are, in addition, other specialty populations served in the public sector: homeless adults and families; mentally ill adults in the forensic system (in and outside institutions); people with mental illness and other chronic medical illnesses; people living with AIDS; and people suffering from PTSD.

A report titled Education for Community Psychiatry issued by the Group for the Advancement of Psychiatry (GAP) documented the training programs in existence in the mid-1960s. These programs were 1–2 years in length, and combined didactic training with field experiences. Areas of focus reflected the diversity of services that were being developed at that time: consultation, prevention, program planning, and research activities in community settings. A minority of the program emphasized administration.

The GAP report listed seven programs training psychiatrists exclusively

1. *Albert Einstein College of Medicine*—The Social and Community Psychiatry Fellowship trained three to five fellows for 1–2 years. Courses included social psychiatry, communications theory, epidemiology, and research design. Programs were individually tailored, but each Fellow spent time in a day hospital, a family therapy seminar, a community consultation service, and conducting a small research project.
2. *Boston State Hospital*—an Advanced program trained 2 PGY 4 or PGY5 psychiatrists for 1 year and focused on psychiatric leadership in community services. "Intensive social psychiatry seminar work" provided training in a variety of hospital and community settings, with options for training in brief treatment, home treatment, family therapy, consultation, mental health planning (with the Department of Mental Health of the State of Massachusetts).
3. *Columbia University*—The Traineeship in Community and Social Psychiatry trained four to five Fellows for 2 years with an MS or MPH available. An extensive didactic curriculum covered legal aspects of psychiatry, hospital administration, consulting, communication, ward management, social psychiatry, government processes, and epidemiology. "Supervised field placements (were) chosen from settings that emphasize prevention, rehabilitation and community planning."
4. *Massachusetts General Hospital (MGH)*—Training in Community Mental Health for Psychiatrists trained two "clinician–practitioner–administrators" in a 1–2-year program.

The ratio of time devoted to didactic to practical experiences was 40/60. Courses covered community processes, epidemiology, crisis intervention, consultation, group dynamics, research and communication, plus "some emphasis on administration." Field experiences took place at various units of MGH, especially the Human Relations Service of Wellesley, Inc.

5. *Menninger Foundation*—The Post Residency Fellowship in Community Psychiatry trained four fellows in each of 2 years to become "consultants, administrators and investigators of psychosocial phenomena." Fellows were placed in at least two of five divisions: Law and Psychiatry, Religion and Psychiatry, School Mental Health, Industrial Mental Health, Psychosocial Research. Each division offered field experiences. Courses covered consultation, group and family dynamics, collaboration and communication, research and epidemiology. Each fellow carried out a research project.
6. *The Institute of the Pennsylvania Hospital Community Psychiatry* trained two fellows in a 1–2 year program. The program provided a "continuing seminar on all aspects of social psychiatry" including prejudice and discrimination, community crises and disorganization, urban renewal, hospitalization, and administrative practices. Field placements included court agencies, adoption agencies, hospitals, halfway houses, schools and Department of Welfare.
7. *The University of California in Los Angeles (UCLA)*—The Social and Community Psychiatry Training Program trained seven fellows in a 2-year program leading to MPH. The didactic program focused on consultation, preventive psychiatry, research, epidemiology, and "recommended therapeutic practices for the treatment of existing and future community mental health problems." Courses covered social sciences, social psychiatry, community structure, consultation, epidemiology, administration, social class, and culture.

There were an additional five programs training psychiatrists alongside other MH professionals

1. *Center for Training in Community Psychiatry and Mental Health Administration,* (Berkeley CA) trained three psychiatrists at PGY4 or PGY5 level alongside 205 trainees, 88 of which were psychiatric residents. An MPH was available. The program focused on didactic training and "affiliations with field work placements."
2. *Harvard Medical School Educational Program in Community Mental Health of the Laboratory of Community Psychiatry* trained 10–18 psychiatrists, psychologists, social workers and nurses in a 1-year program. Half time was spent in seminars covering research methodology, administration, consultation, group process, legal aspects, and preventive psychiatry. The other half time was spent in "supervised field experiences and participation in community mental health research and practice." This program was originally created by Gerald Caplan in the mid-1950s at the Harvard School of Public Health, and transferred to the Laboratory of Community Psychiatry in 1964 (Caplan 1970).
3. *Johns Hopkins Public Health-Mental Health* trained approximately seven to ten "mental hygiene specialists" (psychiatrists, psychologists, nurses, and social workers) among 70 students. The program provided 1 year of training in biostatistics, epidemiology, prevention and administration.
4. *Langley Porter Community Mental Health Training Program* trained psychiatrists and psychologists in a 1–2-year program. There were two-year-long 90-min seminars in "Methods and Practices" and "Principles and Theory" in Community Mental Health Field. Each fellow undertook an "intensive study of a particular problem relevant to community mental health" and had an "opportunity for observation and participation in …community mental health service programs." Psychiatrists were supported by NIMH stipends.
5. *Yale—Public Health Psychiatry* trained "not more than six to eight students" including psychiatrists, psychologists, social workers and RNs in a 2-year program leading to an MPH. The program focused on program

development and evaluation, and research. Courses included epidemiology, community psychiatry, social psychiatry, biostatistics, and methodology of social research. Field work experience was provided.

The Social and Community Psychiatry Training program at the University of California, Los Angeles (UCLA) was particularly well documented. It was a 2-year postresidency program originally leading to an MPH degree. The program attempted to integrate social science and public health disciplines within the same program**.** The program, which received support from the National Institute of Mental Health (NIMH), began on July 1, 1962, with the admission of three Fellows. As of 1972, the level of funding had risen as a reflection of the growing demand and provided stipends and teaching support for 12 Fellows-in-training, six at each level of the 2-year program. By 1972, the program had graduated 44 psychiatrists.

> The original goal was to produce psychiatrists… who could assume positions of influence with regard to the future directions of public psychiatry. Other well-known programs tended to more strongly emphasize the techniques and practices (viz., consultative, organizational, administrative, and educational) of community mental health activities. The UCLA program was intended to produce teachers and investigators, as well as sophisticated practitioners in social and community psychiatry. The UCLA program's academic emphasis was markedly interdisciplinary in the social sciences, with a particular focus on sociology and anthropology. (Karno et al. 1974)

Support from the NIMH ended in 1974, and at that time the program was disbanded, but its "core community practicum experience and coursework" were transferred into the general residency training program.

Two other programs were described in separately published manuscripts (Bernard 1964; Caplan 1970). The original program at Columbia was supported by both NIMH and New York State Department of Mental Hygiene funds. This program offered an extensive didactic curriculum including both a "Core Curriculum in Community Psychiatry" as well as "selected courses from the basic courses in Public Health and Administrative Medicine," weekly field visits to a "variety of community and institutional settings" and a "supervised field experience (in research, teaching, or practice)" through an individualized "sequence of field placements," either concurrently or consecutively. There was also an option for a nondegree track. Topics covered included Legal Aspects of Psychiatry, Psychiatric Hospital Administration, Financing, Tools of Communication, Contributions in Social Psychiatry, Epidemiology of Mental Disorders, and Survey Research Methods (Bernard 1964).

The Harvard Program in Community Mental Health was a 1-year program for psychiatrists, psychologists, social workers and nurses, during which fellows spent 3 days a week in seminars and 2 days on supervised field work. There was a 2–3 month full-time internship at the end of the year. There was an ongoing seminar in general mental health consultation throughout the year (Caplan 1970).

The Columbia University Public Psychiatry Fellowship

As mentioned, none of the above programs survived for more than a decade, and there is no evidence of any dedicated postgraduate public or community psychiatry training program functioning during the mid- to late-1970s. The Columbia University PPF was created in 1981, distinct from the earlier program at Columbia. PPF continues today, training ten fellows per year and serving as the model for virtually all other public and community psychiatry training programs currently in existence. A small number of other programs training one to two fellows each were started in the 1980s and 1990s, but none of them survive today.

According to the PPF Web site (ppf.hs.columbia.edu): Public Psychiatry refers to the use of clinical techniques, management skills and evaluation strategies within established institutions serving populations with social as well as psychiatric needs: patients with severe mental illness and other major social psychiatric problems such

as substance abuse, homelessness, and AIDS, as well as members of poor urban and suburban minorities. These groups cannot or do not purchase services of their own choosing and must rely on public funding and services.

Ongoing and published surveys show that 97% of PPF alumni continue to work in the public sector, 67% in leadership roles (Ranz and Stueve 1998). Throughout the 1-year program each of ten fellows spend 3 days a week placed in one public mental health hospitals and agency. At their field placement sites, fellows assume some of the responsibilities of a leadership role by running team meetings, participating in program planning, analyzing budgets and initiating internal program evaluations. Fellows are encouraged to apply for positions as program medical directors (i.e., of clinics, recovery and rehab programs, and ACT teams) at their field placement sites at the end of the fellowship year.

In a personal communication, the founder of the program, C. Christian Beels, MD wrote:

> The reason for choosing Public rather than Community or Social psychiatry was the connotation that the other names had acquired in the 1960s. Grob (1994) wrote that social and community psychiatry had become associated both with the "community mental health center" movement, a federal effort to get states to take up the cause of the severely mentally ill, and with an effort to improve mental health outcomes indirectly by community organizing and improvement of the social environment. We used the word "Public": to convey our commitment to working for existing public (usually state or city) institutions already charged with the care of the long-term mentally ill, the addicted, and the poor or homeless. The problem with the social and community psychiatry movement was that it never really figured out how to be a psychiatrist to a community. There was much discussion about how to deal with homelessness, for example, but few plans to actually provide and supervise homes until nonprofit community-based agencies began to provide government funded services for the homeless in the 1970s. I would add that an important reason for using the word "public" was that it was clearly the opposite of "private," as in private practice and corporate-profit. The image of the psychiatrist as civil servant seemed important. (Beels, personal communication 2011)

Throughout the rest of this chapter, the term Public/Community will be used to refer to these fellowship training programs.

Current Public/Community Psychiatry Fellowship Training Programs

As of 2011, there are 14 programs in existence and two in the serious planning stages. A program was created at Case Western in 2000 and became somewhat dormant until restarted in 2009. Another program was created at Emory in 2001. All the others were created in the past 5 years, partly sparked by recent interest on the part of several states in developing fellowships in public psychiatry. In 2007 PA awarded "Center of Excellence" status (a model developed in Ohio) to three academic centers at the University of Pittsburgh, Lake Erie, and the University of Pennsylvania with mandates and funding to create public sector fellowships with PPF as model. In 2004, California created dedicated mental health funds created by the Mental Health Services Act (Proposition 63, levying a 1% state tax on incomes of $1 million or more). Some of these funds were earmarked for training of mental health professionals. As of 2011 programs are planned in both San Diego and Orange Counties in the spirit of Proposition 63, though with other funds.

Programs were started at Yale and the Durham VA in 2007 and at NYU in 2008. In 2010, programs were started at the University of Texas South Western in Dallas, Texas (USTW), the University of NC-Chapel, Florida, and Alabama, and in 2011 a program was started at the University of California in San Francisco (UCSF). Four of the existing programs are run by Columbia PPF alumni (NYU, Case Western, UTSW, and UCSF).

The Core Elements of a Public Psychiatry Fellowship

In response to requests for consultation from many of these new programs, the Columbia PPF faculty developed seven Core Elements it views essential for such a training program (Ranz et al. 2008).

1. *Academic curriculum covering the essential topics in public psychiatry,* including the Structure Of Public Psychiatry, The Role of the Psychiatrist, Recovery and Psychosocial

Rehabilitation; Internal Program Evaluation; Special Populations: Substance Use Disorders, Posttraumatic Stress Disorder, Homelessness; Fiscal Management; Public Mental Health Advocacy—Including presentations by consumers.

2. *Application of concepts taught in the academic curriculum by Fellows to field placements,* through formal written presentations to other Fellows and faculty: Congruence model analysis of Field Placement organization; Systems-Oriented Clinical Case; Budget; Advocacy and Internal Program Evaluation. Fellows take feedback from these presentations to field placement supervisors as suggestions to inform system change.
3. *Presentations by guest speakers illustrating topics covered in the academic curriculum.*
4. *Practicum in mental health administration*. Sessions teaching basic concepts in mental health administration interspersed with case presentations by alumni who are medical directors in public sector organizations addressing management problems to which Fellows and faculty suggest strategic solutions.
5. *Placement in one public mental health organization throughout the year* to achieve a comprehensive clinical and management experience. Fellows select the agency at which they work 3 days a week throughout the fellowship year. Agencies are chosen with regard to their willingness to allow fellows to assume leadership roles and their track record of providing positive experiences to previous fellows.
6. *Weekly meetings with a faculty preceptor for individual support in academic and field placement experiences.*
7. *Mentorship and other ongoing support from faculty beyond the fellowship year* through above presentations, consultations, reunions, fellowship Web site, and list serve.

In addition, the authors indicated that, in recognition of the importance of group process, new programs are encouraged to start with at least two fellows. If funds were only available for one fellow, a 2 year program was recommended ensuring a minimal group process between first and second year fellows. To guarantee a reasonably complete curriculum, the authors also recommended classes be scheduled a minimum of 1 day per week. If class time has to be limited to one-half day per week, a 2-year program is again recommended.

Regarding funding, the authors indicated that over the years PPF has developed a spectrum of strategies for funding fellows which could serve as viable strategies for developing programs. At one end of the spectrum, the training institution pays the full salary (stipend model), and at the other end the field placement agency pays the full salary (junior faculty model). Intermediary strategies involve sharing of the salary between training institution and field placement agency. The stipend model provides maximum flexibility, while the junior faculty model offers higher salary and incentive for the fellow to remain at the agency after the fellowship year.

AACP Guidelines for Community Psychiatry Fellowships

The publication of the Columbia Core Elements and the renewed interest in developing fellowship programs inspired the AACP to develop "*Guidelines for Developing and Evaluating Public and Community Psychiatry Training Fellowships"* in 2008.

> The purpose of the AACP guidelines is to create a vision for training of psychiatrists that incorporates the capacity to promote health and wellness through a comprehensive conceptualization of human experiences and an integrated, holistic approach to treatment and services. This vision includes elements needed to re-establish psychiatry's strong position in leadership and consultation (http://www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/fellowship.aspx)

Required Elements of Fellowship Program Design

These five elements are derived from the PPF Core Elements, though described in more detail.

1. *Academic or Didactic Curriculum*. The classroom experience should be a significant part of any Public-Community Psychiatry Training Program. Many of the topics that will be covered in the program will be ones that fellows have had little formal exposure to in their general psychiatry training. A broad array of topics should be offered in the fellowship and should include the following: History of Modern Public Psychiatry, Structure of Contemporary Public Psychiatry, Funding of Public Human Services: Federal, State, Local, Administration and Fiscal Management of Behavioral Health Services, Regulation and Accreditation of Public Sector Programs, Comprehensive Elements of Systems Design, The Role of the Psychiatrist in Community Based Services, Recovery Focused Care and Psychosocial Rehabilitation, Practical Program Analysis and Evaluation, Special Populations and Cultural Factors Impacting Clinical Practices, Homelessness and Housing Policy, Providing Leadership and Facilitating Collaboration, Principles of Public Behavioral Health, Interface of Primary Care and Behavioral Health, Transformation in the Structure of Public Behavioral Health, Community Based Research and Scholarship, Public Mental Health Advocacy.
2. *Primary Field Placement.* A primary placement in a community based behavioral health service agency throughout the year will provide a comprehensive and integrated clinical and management experience. It should allow fellows to assume an actual leadership role in these agencies in both clinical and administrative capacities and will allow fellows to become familiar with the dynamics, culture, and politics of the system within which they are working. It is recommended that this placement be given 20 h or more of the fellows' scheduled time throughout the year.
3. *Faculty Supervision and Mentoring.* Fellows should meet weekly with one of the core faculty assigned or selected by them as preceptors. The preceptor role will be to provide primary consultation to the Fellow regarding the Fellow's field placement experience and to discuss various problems or issues that arise within it. The Preceptor will also advise on the preparation of internal and external presentations and discussions, as well as teaching and supervisory activities. This type of relationship will facilitate the integration of the didactic curriculum and the field placement experiences. To assure that this happens, the core faculty should attend all of his or her assigned Fellow's presentations, as well as much of the academic curriculum.
4. *Teaching, Presenting, and Supervising*. Fellows must be provided opportunities to establish or hone teaching and supervisory skills that are essential to providing leadership in any system in which they may eventually work. Problem based or participatory learning formats within the didactic curriculum should provide many opportunities of this kind, with fellows taking the lead in researching and leading discussions on several of the scheduled topics.
5. *Research/Quality Improvement Project*. Programs should provide fellows with an opportunity to develop and lead the implementation of a research or quality improvement project. In most cases, this will be most practical when organized around the primary placement site. Projects that provide useful, relevant information or improvements related to the provision of services will be most beneficial. Opportunities of this type will provide valuable experience in leadership and in overcoming obstacles to achieving desired outcomes. Projects should provide opportunities for the practical application of principles considered in the didactic section of the fellowship.

Other Elements of Fellowship Program Design

6. *Systems Management Skills.* Some fellows or programs may want to emphasize participation in larger systems administering behavioral health care.

7. *Community, Consumer, or Family Advocacy.* Programs or individual fellows may wish to develop a public health focus by enhancing organizational skills useful in advocating for change or empowerment of various stakeholder groups.
8. *Recovery/Resiliency Oriented Services.* As consumers become more and more invested in directing their own care and making choices about the services they receive, and as transformation efforts gain momentum at the federal, state, and local levels, it will be important that fellows have a thorough understanding of recovery and resiliency principles and how services can be delivered in a manner that supports them.
9. *Cultural Disparities, Competency and Sensitivity.* A program, or a fellow within a program, may wish to focus on obtaining competence in the treatment of a particular cultural group, developing sensitivity to relevant issues and addressing them in clinical practice, or in transforming systems of care in a manner that reduces the obstacles to receiving competent care that members of many groups encounter.

Survey of Public/Community Psychiatry Fellowships

Starting in 2008, directors of public/community psychiatry fellowships have been meeting at the yearly Institute for Psychiatric Services conference**.** In 2009 potential applicants were invited to attend the meeting. A yearly survey form has served to create a common database for all programs**.** Following is a summary of the 2010 Survey of Public/Community Psychiatry Fellowships including reports from 14 programs.

Most programs are training one to three Fellows a year, with only two programs training more than four fellows per year. Most are 1-year programs, but a minority offer a second year. Four programs fund fellows using the stipend model, three use the junior faculty model, and seven use hybrids of the two models. Most programs offer 3–10 h a week of dedicated didactic curriculum. The typical program places a fellow 20–30 h per week in a primary field placement, but minority of programs provide the opportunity for any given fellow to participate in a variety of placement experiences. Most programs offer a choice from a variety of field placements options, and a minority offer fixed placements. Most programs offer predominantly community-based field placements options, but one program focuses exclusively on hospital-based options. The average percent of time spent on clinical activities at field placements is 70–75%, with 10–25% time spent on administrative activities, and the remainder on evaluation/research, training/supervision of other students and advocacy activities. When asked to indicate the priority of each of the following in the fellowship's mission, leadership development was ranked highest, clinical services to public sector patients second and promoting recovery-oriented services third. Advocacy, policy development, and research/evaluation received varying degrees of attention. Several programs offer distinct elements: One program is integrated with an MPH program, and two have focus on rural psychiatry. Several offer training starting at the PGY4 year. Several programs invite other professionals and even consumers to participate in their didactic curriculum, and several others focus on integration with primary care. The Pittsburgh program developed a video seminar series in conjunction with the AACP called the "Community Psychiatry Forum" The topics are selected to be practical and timely. Consumers, family members, behavioral health clinicians, and administrators are represented on the panels of most sessions, offering diverse perspectives on the chosen topic. Continuing Medical Education credits are available for live participation and through viewing the archived sessions without charge to participants.

Conclusion: Developing Network of Public/Community Psychiatry Fellowships

Through the adoption of the Core Elements and AACP Guidelines and the yearly network meetings it is hoped that the newly developed public/community psychiatry fellowships will be

sustained through the inception and difficult years of early implementation. The new training programs have increased the number of psychiatrists prepared to meet the recruitment/retention needs of the public sector. It is anticipated that interaction within the network of public/community psychiatry fellowships will improve the overall quality of training among all programs, ultimately producing a new generation of psychiatrists in public sector leadership positions delivering high quality of care to their patients.

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49 Mentoring, Supervision, and Consultation in Community Mental Health

Joel S. Feiner

Introduction

The community psychiatrist, besides being a clinician and/or an administrator plays a significant role in the development of practitioners of this important subspecialty of psychiatry. The knowledge, skills, attitudes, and values of the community psychiatrist are transmitted from an experienced practitioner to a less experienced one through three overlapping interactive processes: supervision, consultation and mentoring. Brief definitions of these processes are provided before we spend the major part of this chapter on mentoring.

Supervision

Supervision is by far the standard process through which neophytes or less experienced professionals are introduced to the practices and/or administrative issues that they will be facing in their careers. Within the supervisor-supervisee relationship, problems are presented and possible solutions are generated. In the process, skills are developed and refined. Supervisees are provided with support and performance oversight. The relationship provides understanding and skills leading to enhanced ability as well as the knowledge base. The supervision is usually time limited. In many clinical supervision settings, the licensed supervisor is supervising an unlicensed supervisee and is responsible for the care of the patient. In this situation, the relationship likely includes a "you must" rather than a "you should" process. Support in the service of ameliorating professional or personal stress is a part of this repertoire.

Supervision may begin by a discussion of each person's expectations until a mutually agreeable process is agreed upon. It is very likely that significant time and effort will be spent on relational dimensions, particularly as they are involved in the clinical encounter. These foci are primarily engagement, relationship development and maintenance, and listening. (As someone recently said, "We have two ears and one mouth.") The therapeutic process is also advanced through the supervisor's efforts to avoid judgmental statements and advice giving, or too much micromanagement. Many other issues related to knowledge, skills, attitudes, and values are introduced as the clinical or administrative work proceeds. In some cases, the supervisor discusses cases in depth as a formulation evolves, changes in strategies develop and the treatment relationship is scrutinized.

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Consultation

Consultation is generally more focused than supervision and is often centered on a particular clinical or administrative problem. Although consultation may be requested by an individual regarding a particular problem or case, it is more often an ongoing relationship that involves working with a particular group or team. Consultation is usually invited as opposed to the more mandatory nature of arranged supervision.

Working in a state hospital in various capacities, I was often consulted by psychiatrists who have recently been hired after finishing their residency programs. Issues raised were often related to administrative matters, dysfunctional organizational dynamics or interpersonal difficulties. I have always found the principles of family systems (and psychodynamics) to be particularly helpful in dealing with the politics of various systems and informing the consultation I could provide.

Gerald Caplan first developed a role for the psychiatrist as a community consultant (Caplan 1964). Consultants may be engaged in a number of ways and around a number of issues. The consultant may work with a treatment team to assist them in thinking about clinical management, program development, and outcome measurement. In this case, consultation can be thought of as a kind of group supervision, and this model may be used to support an expanded reach of services in situations where psychiatric time is scarce and insufficient to meet needs by providing direct care. The consultant may also be engaged by larger systems to assist in the design, improvement, and evaluation of services. In some cases, the consultation might be sought by the community for assistance in managing a crisis, developing public health and prevention policies, or simply to provide education or assist with organization.

Mentoring

Writing about mentoring often begins by citing The Odyssey, in which Athena, the goddess of wisdom, appeared in the form of Mentor in order to advise Telemachus, Odysseus' son, in the latter's search for his father. In recent years, the literature on mentorship has developed in the field of psychiatry. Rodenhauser et al. (2000) extensively reviewed the mentorship relationship in psychiatry. They noted that the business world was the first area for mentoring. As is the case with the business literature, "the limited literature on mentoring in psychiatry has come from administrative psychiatrists," who have consistently placed a high value on mentoring. Sherwood et al. (1986) found a very high percentage of leaders in psychiatry who acknowledge at least "one influential role-model during their training." Ranz (Ranz and Steuve 1998; Ranz 2004; Ranz et al. 2006), who has been instrumental in developing the longstanding Fellowship in Public Psychiatry at Columbia, considers mentoring a central dimension of the program. Otherwise, there is little if any literature specifically discussing mentoring in community psychiatry. Because of this fact, I have chosen to draw significantly upon my own mentoring experience. I use the impressions of a number of colleagues with whom I have had a mentoring relationship. They have been willing to describe the nature of that relationship and what impact it had upon their professional development. These communications, along with my observations, provide the substance of this chapter.

I have had a long career in community psychiatry working with significant figures in its evolution and in a number of model programs, which always had an academic affiliation. Willie Sutton, the bank robber, when asked why he robbed banks, responded, "That's where the money is!" Analogously, medical schools are where students and residents with potential interests in community psychiatry are found. In order to prepare the next generation of clinicians, it is important to engage them early. Having access to the knowledge and expertise within the medical school has also been a great advantage for the clinical work that has been a significant part of my practice. In thinking back about my protégés (I've borrowed that label from Rodenhauser et al. 2000, instead of "mentee"), many of these relationships were developed in the course of other mutual tasks and

were not labeled as mentorships. Calling them mentorships was something that usually occurred some years later. I have been thinking of my own experience as a protégé. My primary mentor was Israel Zwerling, MD, PhD, a giant (not in size) first generation community psychiatrist and a psychoanalyst as many psychiatrists were in the 1960s. Iz recognized early that a broad view of psychiatry included a social justice agenda. He was part of the generation that expanded research in social psychiatry. Important social issues shown to have a significant impact upon human development were poverty, social class, and race. Iz taught me how to practice psychiatry in a way that resonated with my evolving concern with social justice.

Iz was one of the progenitors of the family therapy movement. He was not only a practitioner but also an important figure in the development, within the Bronx Psychiatric Center, of a center for family therapy research, training and practice. A number of leaders in family therapy and in community psychiatry trained and worked in that center. It is clear that the systems perspective, so intrinsic to family therapy, opened the thinking of practitioners to social and environmental factors that impact upon the breadth of human development (Rosenbaum and Zwerling 1964). This orientation led to intervention possibilities in therapeutic practice. I met regularly with him during my teaching fellowship, and I felt that Iz respected me and liked me. Of course, the feeling was mutual, so the relationship was very supportive. He endorsed some ideas of mine that I thought were creative, and although most of them never got off the ground, they did stretch my mind. He taught me and showed me how I could be effective. Of significance, I learned the importance of modeling in the mentoring process. In looking back now, early in retirement, I have interacted with a number of younger colleagues who graciously feel that we had a mentoring relationship. I have realized that there has been a considerable amount of variation from my relationship with Iz, but also some similarities. The fact that these mentorships occurred under the umbrella of community psychiatry is a relevant issue. In general, the persons that we treat are on the margins of society and have few material, emotional or human resources. As a result, a team of professionals and paraprofessionals is required to meet their needs. It is therefore essential that we are thinking of the work from a systemic perspective, addressing the "synapses," the elements in the system that must connect effectively. While biologic psychiatrists may have a deep understanding of psychopharmacology, our own expertise in psychosocial concepts includes issues informed by the humanities and other social disciplines such as anthropology, literature, social psychology, and even economics and political science. As a result, a mentorship is more than supervision; it is an interrelated complex of information and practice embedded in an open, close, and respectful relationship. The mentoring process may draw upon a wide range of experience and knowledge, both academic and personal. Supervision is more likely to focus upon direct patient care, administrative issues or research projects.

Initiating a Relationship with a Mentor

There are many ways in which mentoring relationships can be initiated. These processes may come about as part of a program's effort to provide residents with exposure to a more senior person or role model, usually a psychiatrist. When a trainee enters a program, a pairing is likely to be made through assignment by the training program director who matches the interests of the trainees and faculty. The mandate is not necessarily defined clearly, but in many cases this lack of definition allows for a creative interaction and evolution. The faculty member may serve as a person to assist the resident in adapting to the program or to psychiatry in general. Meetings may be regular but are often arranged on an as needed basis and usually they are entirely optional. Assignments and selection may be made based upon areas of interest or experience (e.g., research or shared cultural backgrounds). The main characteristics of supervision and mentoring are presented in Table 49.1 along with the major similarities between them.

Table 49.1 Characteristics of supervision and mentoring

Supervision
More focus upon getting specific work or job done, whether it is clinical treatment, administrative work, or research tasks
Quality monitoring of the clinical work is necessary
Supervisor may be responsible for signing off on work and may include "you must"
Process is a formal part of the training process
Evaluation is likely a formal part of the process
The relationship is likely to be time-limited
Mentoring
Broader range of issues addressing career development as a significant dimension of human development
Less direct supervision but supervision and consultation may be included
Mentor utilizes modeling and expansion of protégé's network
Mentoring often includes a more mutually personal relationship
Mentor may introduce more contextual issues in a direct way
Usually includes substantial discussions of career and work
Informal, voluntary arrangement
Evaluation is not required, may be more informal
Similarities
Introduces systemic thinking
Use engagement, relationship development, and maintenance in the dyadic relationship
Mentor and supervisor work to generate enthusiasm for the work
Mentor and supervisor are both prepared to provide professional and/or personal support
Emphasize strengths and abiding positive interaction
Introducing reframing techniques
Mentor and supervisor focus upon knowledge, skills, attitudes, and values
Tolerance of disagreements and willingness to facilitate open discussion
Address cross-cultural and transethnic issues as a comfortable part of therapeutic or administrative process

Mentors and potential protégés come together in a variety of ways and for a variety of reasons, but in many cases it is the protégé that seeks the relationship. In these cases the relationship simply evolves, rather than growing out of a formal matching. I have had a range of protégés and the word mentor was rarely used at the time, but it was clear that the process and content was different than supervision. Mentoring often extends over a period of years, and in many cases, lasts throughout the course of careers, evolving into more of a friendship than any kind of formal, academic arrangement. It will often include discussions that help clarify the relationship of knowledge and values to the clinical context, career development, and personal issues. The protégé will often shadow the mentor to relevant meetings in the community or clinical settings and or join in observe.

There are several examples of training oriented relationships that emerge as mentorships, some of them outlined as follows:

1. Traditional supervision evolves with the inclusion of community psychiatric interventions and settings into a deeper relationship. The discussion of treatment for individual clients continues while the interaction broadens.
2. A trainee or early career psychiatrist (ECP) requests assistance with an administrative issue which turns out to be very helpful and then leads to continued consultations and eventually broader conversations. This burgeoning interaction evolves into a mentorship.
3. A program medical director has an opportunity to work with an ECP who is working in her program. The interaction involves frequent interaction and modeling around clinical and administrative processes, problem solving, role definition, resident and medical student supervision and training. They find their interaction mutually satisfying and constructive.
4. A nonpsychiatric mental health professional who occupies a key clinical and administrative role may begin to consult with an experienced psychiatrist around concerns involving systems issues, role definition, interprofessional discord. These ongoing discussions evolve into a mentoring relationship.
5. A senior community psychiatrist provides an elective experience for PGY3s/and PGY4s interested in community psychiatry using an apprenticeship model in which the resident spends one half to 1 day per week observing his or her clinical practice in a community psychiatry setting. This kind of interaction enables residents to experience the community psychiatrist at work—with consumers, family members, and teams, in the community and at meetings in the workplace. The experience

develops beyond the clinical observations and evolves into a relationship which continues beyond the scheduled experience.

6. An older, more experienced psychiatrist has the opportunity to recognize promising residents or young psychiatrists through collaborative projects or supervision. He identifies issues of interest to engage the potential protégé. Through this beginning, he introduces a broader set of interests and perspectives and nurtures their development.
7. A psychiatrist is assigned a supervisee of distinct ethnicity and cultural background. He develops a rapport by specifically addressing issues related to these possible differences and demonstrates respect for and interest in them. A mutual respect and interchange develops that lasts beyond the supervision and he is often consulted on issues related not only to cultural dissonance, but on other personal and professional issues as well.

The Resident as an Apprentice

As Medical Director of the Comprehensive Homeless Program in the local medical school affiliated VA hospital, my clinical work had significant elements of community psychiatry: working with homeless veterans on supported employment, entry level work programs, a range of housing programs, and other rehabilitation activities all within an energing Recovery Framework. I had a significant panel of patients and I met regularly with teams to review the treatment plan for consumers with particularly difficult problems. This milieu provided an ideal opportunity to work with residents, taking advantage of "teaching moments" presented. I also attended arrange of community based meetings, including monthly VAMC meetings, and had close ties to the homeless services system within the community. The job description is elaborated because it was instrumental in deciding with residents what their elective would consist of and how it developed into a mentoring relationship.

With each resident a plan was constructed for their 4 month elective, during which they would spend 1 day per week with me. Probably the most important relational dimension in working with consumers is trust, based upon their feeling understood. The residents would sit in with me as I saw the consumers with the latter's explicit approval. In this format, the residents could observe our interaction and the evolution of a trusting relationship. In addition, the resident would sit in on team meetings that took place on the days of their elective. Various half-days during the elective they would participate in a range of community based experiences that they otherwise would not have exposure to in their training. These activities included joining the VA's homeless outreach team, making home visits with a peer specialist, and visiting various programs to which they referred consumers such as shelters. We also spent time discussing their roles, training struggles, and realistic considerations about job prospects.

The residents appreciated my openness and personal interest in getting to know them. In this way, I was able to modify some of their experiences to better coincide with their individual professional interests. They felt the experience of seeing an experienced psychiatrist working with patients was a unique aspect of their residency. One resident observed that some of the patients we saw were originally labeled "difficult patients" and were now proceeding along constructive paths. During this experience, the residents learned about engagement and search for strengths, with enthusiasm and passion in the process. They had an opportunity to find their own style. They were able to expand their awareness of other jobs in community psychiatry as well as clinical, administrative, and research issues to be addressed. The protégés learned to collaborate with the consumer and to reframe. They were immersed in the recovery frame of references. They came to appreciate the place for advocacy in working with marginalized and isolated persons. I made it a point to expand their network of professionals, administrators, family members and consumers active in the local human services effort. This process was a significant expansion of the residency training experience. Finally, I encouraged their membership in the American Association of Community Psychiatry (AACP) as a means for shaping their identities as community psychiatrists. Their

attendance as the Institute for Psychiatric Services meeting was also encouraged as a way to help to extend their network, with the help as a catalyst.

Early Career Psychiatrists (ECPs) as Protégés

ECPs were working in a program in which I was the director and visible as clinician and administrator. Discussions often focused upon the context of the clinical program, the training program, and the community. They were open and honest. The discussions were occasionally focused, occasionally meandering, often late in the afternoon. The process was likely responsible for the evolution of the following results so well articulated by a formerly early career community psychiatrist.

> Wisdom shared is one of the most important elements of the mentor–mentee relationship. The mentor has to offer it, and the mentee has to absorb it. I think we both did our parts. The most useful administrative tool I learned was how to provide input to an administration in a way that advanced change in a harmonious way. I learned how to teach my trainees that whatever system you join, its structure has a rationale that is not apparent to you at the onset and maybe hidden. I was young and had to learn. My mentor was older and had plenty to teach. There has to be goodness of fit between the mentor and the mentee; we melded well.....Clinically, the mentorship helped me move from a doctor-centered paternalistic framework to a patient-centered, recovery-oriented one.....A mentor teaches timeless lessons, ones that the mentee, as he or she develops, can pass on to those who follow him/her. In that sense, it is wisdom that is passed on, not information; information changes, but wisdom, like virtue endures. A mentor does not just pass on information. Good information, like directions to the nearest gas station given by a stranger, does not require a positive, reciprocal, personal relationship. A good mentor gives feedback, receives feedback and modifies his or her assistance based on the feedback..... The mentoring was morale-restoring and morale-maintaining in a way reminiscent of Jerome Frank. It was indirectly therapeutic, and I think good mentoring has to be. Good mentorship, like family psycho-education, cannot be brief and be effective. I know that sharing the same work space for two years had a huge impact on my learning. By giving my career a focus, it allowed me to say "yes" to one direction, and "no" to many other ways I could have gone, but would not have loved. By the way, I get accused of being a social worker. A high compliment, no? Show me the science, "continues to ring in my head as a useful marker."

Another ECP with whom I worked, was a graduate of the Columbia Public Psychiatry program and maintained contact with Dr. Jules Ranz, founder and director of the program and a consummate mentor. This protégé also developed a mentoring relationship with me. This bond has continued both as a friendship and as an ad hoc consultation relationship. It is not uncommon for a protégé to have several mentors. The issues we addressed were related to the professional developmental needs of the protégé. He was able to observe my activity as community psychiatrist, which included advocacy, recovery, clinical formulate teamwork, and clinical leadership. I attempted to convey my belief that our work is a sacred privilege. As a mentor, I also became aware of my protégé's values and abiding integrity, as he became aware of mine. Working with a mentor directly offers the advantages of an apprenticeship. This protégé reports that in the course of working in the same program, he was able to profit from modeling related to my interests in areas such as rehabilitation, focused patient interviews and participating in staff meetings. He also absorbed the culture of the program. He also benefitted from access to my network, which led to a connection to the program for which he is currently Medical Director. We were also willing and able to disagree about issues related to our work, leading to a productive interchange. The apprenticeship model can be the most effective and intense type of mentoring process. The protégé is able to hear not just the words but to experience the music. The close interaction maximizes not just the content of a community psychiatrist's work but the context.

Shared Interests and Goals

A significant format for mentoring involves the mentor and protégé coming together in the course of participation in a project of some kind. It may be a research project or it may involve program development. One of the fortuitous opportunities

I had to develop a mentoring relationship emerged from a mandate to develop and supervise training wards at state hospital where I worked. One of the two training wards was to be run by a recently graduated, carefully selected former chief resident. I was the training director at the time and I immediately established weekly meetings to discuss the issues that came up in the course of this project. The task was to establish a state of the art inpatient program which would engage residents, psychology interns, social work students, activity therapists, and paraprofessionals as trainee members of well-integrated clinical teams in the comprehensive work of the ward in which we tried to ensure that all persons grew and developed. His reflections upon our mentoring time together include the following: "I could ask you anything and you tapped into your experience and shared it readily; you also helped with concrete issues. You were open to my ideas, some grandiose and some wrong, but you gave me room to explore and learned with me. Your availability as well as your positive regard and trust in me…was extremely important."

A mentor to a protégé involved in program development is in a position to facilitate evasion of obstacles the protégé might not otherwise be aware of. In the process, significant value based skills are added to the protégé's repertoire. One protégé highly valued learning to make relationships with the community and to see value in participating in professional and advocacy organizations. He himself, as well as others like him, have become valued mentors.

Beautiful Swans

There is another group of professionals who are potential beneficiaries of mentoring. They might be called "the ugly ducklings" (who are really "beautiful swans"). These professionals—residents, early career professionals or allied mental health professionals—may not be considered "a good fit" for some residency programs or certain professional activities. They may appear eccentric, having taken nontraditional paths to medical school. They are often from other cultures and may wish to serve needy persons who have been immigrants and refugees. Although they may be seen as marginal, they are often determined and tenacious. Weidman (1986) uses the term "culture brokers," professionals who bridge the gap between scientific psychiatry and culture-based helping techniques. This group of people usually welcomes assistance in moving into new roles, gaining acceptance, and receiving help developing networks that support their interests. Working with this group can be quite gratifying for mentors and the relationships lasting.

Mentoring the Nonpsychiatric Professional

The opportunity to mentor a nonpsychiatrist may present itself in community psychiatry work.

There are settings in which transprofessional mentoring can be comfortably provided.

1. Supervision, particularly around a specific modality, e.g., group or family therapy.
2. Program development, in which the protégé has a key role in the program.
3. Supervision, as a member of a nonpsychiatrist's doctoral committee.

I have found that the easiest entree into transprofessional mentoring occurs when the protégé has clinical/administrative responsibility. In the example mentioned above of the new training unit, a well-trained social worker was to assume responsibility for family programming and family therapy for all trainees, including PGY-2 psychiatric residents. If a curriculum is composed of knowledge, skills, attitudes, and values, the mentoring process is one in which the latter two components can be particularly developed. Working with a protégé who has administrative responsibility facilitates the development of a "culture of care". In this system, there was emphasis on community and public psychiatry development.

In multi disciplinary programs there may be discrimination, overt or covert, from some disciplines toward administrators from other disciplines. Working with protégés toward the development of mutual respect and sensitive interventions, etc. is a worthy goal. Once again, the mentor must model respect, openness, and

emphasize strengths of the protégé. The social worker mentioned above absorbed a sense of empowerment and confidence as well as a deep dedication to the program. She became a respected contributing member of the executive team with a sensitive awareness of systems issues. She felt that the modeling she observed through the mentoring experience contributed to the inclusiveness that evolved in this new enterprise. She became aware of the dimensions of teaching, modeling, advocating and empowering. Her own significant strengths have emerged and she has become well respected within the academic department. Like so much in our field, the relationship is central. There have been occasions when it has been important for the mentor to be available in a professional or personal crisis. Clearly, the kind of relationship that has been most supportive is a facilitating one rather than a prescriptive one. Network building should be emphasized and demonstrated. It is a community psychiatry necessity both clinically and programmatically. This process includes encouragement of the protégé's participation in local community organizations as well as national professional organizations. It is useful for the protégé to be aware of the mentor's professional activities. Finally, perhaps the most nurturing part of the process is the mutuality. Both members of the mentoring dyad are adults with unique experiences that may be brought to bear upon the developmental task at hand.

Conclusion

Clearly, my experience as someone who has, in retrospect, been engaged in mentoring relationships, has been profoundly important to me. It may be the way I define myself to myself. I have enormous pride in the accomplishments and contributions of those with whom I was so fortunate to connect. I like to think that they brought out the best in me. In most cases, I like to think that we have come to love each other and look forward to seeing each other. These are each a unique relationship, aren't they? They feel developmentally necessary and inevitably epigenetically fulfilling. Thanks to you all, protégés!

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50 Ethics for Community Psychiatry: Evidence-Based Policies and Procedures

H. Steven Moffic and Herb Bateman

Perhaps the most important actors will be consumers and their families who organize to assert their will and refuse to allow the status quo to persist since hope and a life of contribution in the community are possible for people with serious mental illness if we do the right things

(Sederer 2010).

It has been said that community psychiatrists and community psychiatry are ethical just by the nature of the work that is done. After all, community psychiatrists and their colleagues choose to work with those that are traditionally underserved: the poor, the minorities, and those with more severe and chronic psychiatric disorders. This fits into what has been called Virtue Ethics, and dates back to Plato and Socrates. This philosophy emphasizes the virtuous character of individuals who have to make choices. That seems good and true as far as it goes. But ethics is never so simple. Even if one chooses to serve the underserved, does one do that competently? Since community psychiatrists often work with other mental healthcare disciplines, do they complement one another? Since mental healthcare providers usually work in an organization, does that organization value quality of care as much as costs of care? Do the needs of those served justify more flexible boundaries of interaction? This chapter seeks to address the ethical quandaries and principles found in community psychiatry.

Sometimes providers have to choose between two or more ethical "goods." Such decisions can be a source of anguish for the virtuous. For example, does the clinician provide what is thought to be best and/or incorporate the desires of those served, especially when what they want is not considered therapeutic? When do providers need to force and enforce treatment and when do they accept noncompliance as appropriate refusal of treatment? When money only goes so far, how do decision-makers distribute (aka ration) time and resources? To those who seem to need it more? To the sickest? To clinician favorites? To whomever the system of care is best able to treat? A little for all? Any ethical principles worth their practical salt have to help and guide mental healthcare providers answer these questions in everyday clinical life.

Traditional Ethical Principles in Medicine and Psychiatry

All ethical principles have their limitations because they may reflect particular activities or because values vary across different professions and cultures. That is why more than one set of principles is often necessary. Of course, these principles have to be remembered, internalized, or rapidly accessible to be of clinical usage.

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For community psychiatry, one may start with time-tested ethical principles. The most traditional are the Ethical Principles of the American Medical Association (AMA), which was the first national code of ethics in medicine. Although intermittently revised over the last 160 years, some basic principles for all physicians have been fairly constant, especially in the Preamble. The Preamble states that the physician's primary responsibility is first and foremost to the needs of patients, but that physicians also have secondary ethical responsibility to society, to colleagues, and to themselves. For psychiatrists in particular, the American Psychiatric Association (APA) adopted these principles and gradually added annotations that specifically reference some of the unique ethical challenges for psychiatrists (American Psychiatric Association 2008). In the last decade, the APA looked into developing its own principles. Many community psychiatrists became concerned that some of the suggested revisions seemed to emphasize psychoanalytic principles over others more relevant to them, their practice, and their patients. They would have made the usual more flexible boundaries, such as attending patient social events, working with consumer advocacy groups, or having a patient also be a peer counselor, appear unethical when they typically were not, as long as such interactions could be justified as being therapeutic for the patients. Sometimes, community psychiatrists have had to stretch the boundaries of honesty in order to manipulate the system to get patients the care they need. For now, revisions to the APA ethic principles are on hold, but the process illustrated the uniqueness and misunderstandings of the work of community psychiatrists.

Newer Ethical Principles

As medicine came to be practiced more and more in group or organizational settings, organizational ethics developed to complement professional ethics. Managed care forced more attention on the business ethics of such organizations. In community psychiatry, the role of the Medical Director had to include grappling to resolve the inevitable tensions between these principles. The founder of the American Association of Community Psychiatrist (AACP) summarized this challenge by stressing that the Medical Director had to have authority commensurate with the assumed responsibility (Vaccaro and Clark 1996). If not, that Medical Director would need to consider resigning or expect to cause sufficient conflict to be fired.

To try to balance these differing ethical priorities, the American Association of Psychiatric Administrators decided that the AMA principles had to—and could—be adapted to psychiatric organizations. This decision led to the "Ethical Principles for Psychiatric Administrators" published in 2000 (American Association of Psychiatric Administrators 2000). Recent research supports the relevance of this project, as it appears that ethical organizations have less trouble following regulations, being compliant, and providing higher quality of service (Ethics Resource Center 2010).

Another recent ethical concern discussed in the literature is that ethical principles of particular professionals, like physicians, may not apply to all the different professionals and perspectives involved in healthcare decisions. The results, often spearheaded by philosophers interested in practical applications of their thinking, were the principals of Bioethics that emerged in the 1970s. Extending the attention given to various human rights issues from the 1960s, the principle of autonomy was added to the more traditional ones of beneficence, do no harm, and justice (Beauchamp and Childress 2001). It is this additional principle of autonomy that is especially relevant to psychiatrists in general, and community psychiatrists in particular. Many of the theories and practices of psychiatry are designed not only to reduce symptoms, but to free patients to make new and broader choices in their lives. Freud stressed that conflicts, often unconscious in nature, doomed people to repeat problems unless adequately recognized and addressed. Cognitive-behavioral psychotherapy (CBT) is designed to help patients reframe the adverse way they think about certain things. Obviously, severe depression, anxiety, or psychosis will limit the

options that patients may be able to see and take. It should be no surprise that community psychiatry, as part of community mental health, emerged as the offspring of the marriage of the civil rights movement of the 1960s and the emergence of bioethics in the 1970s; the issue of patient autonomy has expanded dramatically in community psychiatry.

The Values of Those We Serve

As community mental health first emerged, it continued to emphasize many traditional medical ethical principles, especially beneficence, the actions that promote the well-being of others. However, a review of the early 1960s reflects that what systems of care and decision-makers thought might promote well-being did not always have the intended results. Neither patients nor families were asked if they wanted the massive, and often rapid, deinstitutionalization of state hospitals, especially if community services turned out to be inadequate and some ended up homeless. The original principles of federally funded community mental health—as comprehensive and well intentioned as they were—did not include much input from the public it was to serve.

Perhaps this transformation sufficed until federal funding changed and decreased under President Reagan in the early 1980s. Eventually managed care arrived to further reduce services and posed new ethical challenges (Moffic 1997). As services declined, varied in quality, and became more fragmented, both psychiatrists and the patients reacted to try to fill in the gaps. Some psychiatrists formed the AACP, with the following mission statement: "to encourage, equip, and empower community and public psychiatrists to develop and implement policies and high-quality procedures that promote individual, family, and community resilience and recovery."

Families formed the National Alliance for the Mentally Ill (NAMI) in order to increase the availability of services for their loved ones and for mutual support. They have been quite successful politically in raising awareness regarding mental illness, in advocating for adequate funding of services, and in educating patients, family members, providers, and communities regarding the spectrum of challenges faced by those with mental illness.

Patients themselves began to speak about what they thought they needed, including a new nomenclature, reflecting what is now called the consumer movement. Recent research validates the value of such endeavors, as community mental health centers achieve better outcomes if they work with certain kinds of self-help groups (Segal et al. 2010). The most effective self-help groups seem to be organized from the "bottom up" and controlled by the patients. A new focus in psychology, called positive psychology, has emphasized that providers and consumers alike may need to focus as much on strengths and skills as on symptoms and weaknesses. Taken all together, these developments have led to a renewed emphasis on *recovery*. For recovery, the goals have become whatever patients feel is necessary to improve the overall quality of their lives, not just the reduction of symptoms. The rise of the consumer movement, focusing on recovery, provides a de facto kind of proof that consumer values have not been adequately incorporated into other relevant ethical perspectives. To do so, community psychiatrists continue to need more feedback from them.

In a study examining what consumers wanted in psychiatric emergencies, the consensus endorsed alternatives to emergency rooms, increased use of advance directives, more collaboration, and improved discharge planning in follow-up (Allen et al. 2003). To discover what outpatients of general community mental health centers might currently desire, the authors conducted a pilot study with some consumer leaders of the system in Houston, Texas (Harris County). The consumers completed a brief checklist and survey on what they sought most from community psychiatrists. In summary, these consumer leaders communicated their personal thoughts and feelings, directing them at their care providers:

*You are important to me
*The way you treat me is important
*You have a major impact on my life

*You may be one of the most important people related to my recovery
*The way you treat me can affect my recovery
*It is important that we work together
*I do not like it when you do not include me in your decisions
*Respect matters
*If you do not treat me with respect and compassion, it can have a negative impact on my life and recovery
*I need to know you care
*I need to trust you
*It is difficult for you to help me if I do not trust you
*I need you to listen to my concerns about medication
*Do not judge me
*I can tell when you are judging me
*Your judgment is demeaning
*Please listen and be compassionate; if not, I fear you may hurt me

How might these reactions and recommendations be translated into a "successful" appointment with a community psychiatrist? The Consumer Council Coordinator coauthor provides this recollection of one such psychiatrist:

> He would not tell the patients what to take but would ask them what worked for them. He recognized that they were the experts when it came to their body and mind. They knew what worked, so why not consult with the expert first before prescribing? I could tell the patients were dubious about this doctor. Did he really want to know? Did he really care about my opinion? Then, of all things, he would ask them what dosage worked best. Was this some kind of trick? For many, this was a unique experience. They were being empowered to make a medication decision or at the least, to be a partner in the decision, to provide input. He really believed in the patient's insight into medication since many had been taking it for years. Something else was happening in these doctor sessions: trust was being built.

How is trust built in that situation? If the doctor is going to ask the patient what they thought about a medication or how it worked or did not work, then he is going to have to listen and consider the patient's input. If he is going to ask them how a certain dosage worked, then he has to follow through with the patient's opinion. In other words, if he asked how the 50 mg dose worked and the patient said it was horrible, then he could not ignore their input. Otherwise, why ask? The successful provider will want to know the patient's opinion because he will incorporate their opinion into the final medication decision. Trust is built by listening, respecting what is heard, and working in a partnership.

The coordinator continues:

> He listened. He gave good eye contact and rarely wrote while the patient was talking. He demonstrated compassion. He was not judgmental. He was on time for most appointments. Trust takes time to build. I learned that trust was the medium, so to speak, for effective therapeutic intervention.

These complementary perspectives movingly fit the first Principle of Medical Ethics by the AMA: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights." This principle is from the perspective of the psychiatrist. Turn it around and one begins to understand what the consumers seem to want: With compassion and respect for human dignity and rights, a physician shall be dedicated to providing competent medical care. Such patient-centered care is about the healing relationship between clinicians and patients. In general health care, new research substantiates the many benefits of a positive therapeutic alliance, including better healthcare outcomes, quality of life, adherence to treatment plans, reduced costs, and the reduction of cultural disparities in care (Levinson et al. 2010). Of course, in psychiatry, it has long been known that a positive therapeutic alliance is the essential therapeutic variable in conducting any type of psychotherapy (Frank 1961).

Ethical Principles, Policies, and Procedures for Community Psychiatrists

It should be apparent that there are a variety of ethical principles and values that are relevant to the work of community psychiatrists, but that they differ somewhat in their emphasis and specifics. Good research substantiates that following these principles in an organization will improve outcomes and reduce risk, establishing shared decision-making as an ethical imperative (Drake and Deegan 2009). However, what have not been adequately incorporated into program planning and

day-to-day clinic processes are the values of the consumers of community mental health services, even though research also now indicates that their inclusion in designing treatment plans will increase the likelihood of better recovery.

One way to address this disconnect is to identify what would be the relevant ethical principles and then design a system of care, to ensure that the principles are followed. In an era of increased accountability, one time-tested way to do so is through establishment of clear policies and procedures, just as the mission statement of the AACP originally recommended. An easy way to remember the important principles, since specific ethical principles (other than the patient comes first) in medicine are so easily forgotten, is to use an acronym. The acronym of ETHICS combines reminders of the importance of ethics in the work of community psychiatrists and community psychiatry, no matter how and where it is practiced. Starting with the two traditional ethical principles, four more are then added that are more specific to the work of community psychiatrists.

1. *E*conomic ethics
   Policy: It is self-evident that adequate and competent community psychiatry services cannot be provided without an adequate funding base.
   Procedure: Understand and use principles of business ethics to develop, design, and maintain a cost-effective system of care that benefits as many patients as possible.
2. *T*raditional ethics
   Policy: All community psychiatrists should be familiar with—and try to abide by—the time-tested ethics of physicians as well as all the other mental health disciplines.
   Procedure: As part of continuing education, these principles should be reviewed yearly and incorporated into staff conferences.
3. *H*ope Ethics
   Policy: A realistic possibility of hope for recovery (and expanding one's conceptualization of the definition of recovery) should be incorporated into the belief system of all those who participate in the organization.
   Procedure: Sharing of success stories and consumer feedback.
4. *I*ntegration ethics
   Policy: The needs of the patient consumers should be consistent and connected in all necessary health, social, professional, spiritual, and criminal justice systems.
   Procedure: Connection of these systems should be done contractually, electronically, and personally, with the involvement of consumer representation in all relevant organizations (including the AACP itself).
5. *C*ontinuity ethics
   Policy: Continuity of care, fostered under the leadership of a community psychiatrist, should follow the consumer patient whenever treatment and service is provided.
   Procedure: Clinicians, staff, and consumers bridge systems, being both physically present and informing decision-making processes.
6. *S*trength ethics
   Policy: An emphasis on recognizing, using, and developing the strengths of all patients and consumers, as well as staff, in the engagement and treatment process
   Procedure: Incorporating elements of positive psychology and the principles of recovery into all treatment plans, with clear and adequate informed consent of those served.

Conclusion

> It's easier to fight for one's principles than to live up to them
>
> Adlai Stevenson, politician 1965

Despite all the best intentions of virtuous community psychiatrists, ethics cannot—and should not—be taken for granted. Conflicting and multiple ethical priorities and values require ongoing attention and deliberation, and whenever possible, wisdom. To do so, providers need to combine and blend traditional and modern ethics, as well as commit to the inclusions of the value (and values) of those consumers and their families served, one at a time. All of this should be reflected by documentation in the treatment plan, the symbolic heart and soul of the process of recovery.

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