California's Mental Health Services Act recognized that to transform our mental health services we would need to transform our workforce and put aside money for workforce development and training. An old mentor of mine, Dr. Elpers shamed me into trying to work together with my local residency program and county DMH to try to put together a plan for transforming psychiatrists' training since psychiatrists are regularly identified as a the staff most difficult to transform. I put together this article as a foundation for negotiations and a formal proposal. After months of effort nothing came of it and the MHSA money went elsewhere.

I still think the ideas in this article are worth taking seriously and implementing.

Transforming Psychiatric Residencies

(2005)

There are quite a number of competing interests for the MHSA workforce training money. Perhaps the most challenging is psychiatrists. Achieving the transformation goals of the MHSA could be addressed in three ways by psychiatric residency training programs:

1) Train more psychiatrists to fill the growing need as MHSA creates more services.
2) Train psychiatrists to be more prepared to work in recovery oriented settings without needing retraining.
3) Transform psychiatric residency programs themselves to be an integral part of the new transformed system of care.

1) Train more psychiatrists to fill the growing need as MHSA creates more services.

There are two basic approaches to doing this:

1) Fund more resident positions at programs presently creating high portions of community mental health psychiatrists to do more of what they are presently doing. (It would obviously be better to fund a program where three out of four graduates work in community mental health than a program where only one out of four do. For these purposes working in community mental health would be defined as doing predominantly direct clinical care in voluntary community based programs. Hospital workers, forensic psychiatrists, administrators, researchers, supervisors, for example, while valuable are not working in the jobs the MHSA is likely to create.)

2) Make changes in existing programs so a higher proportion of residents chose to work in community mental health. (This choice implies less residents choosing other career paths. This may be a negative outcome from the point of view of many people involved in some residency programs.)

If we look at the second choice in more detail, historically the most powerful factor in promoting graduates to work in community mental health is exposing them to community mental health during their residency. I remember old studies out of Case Western, Columbia, and UC Davis that reported that if residents were exposed to it, 50% chose to work in community mental health, whereas, if they weren't exposed to it, only 6% did. (I would suspect that decreasing exposure to other sites at the same time would increase that number.)

I visited a Residency program in Toledo Ohio, that as a result of "the Ohio Plan" had 100% of their graduates work in community mental health. In addition to having required clinical rotations in the community they achieved this by the state DMH funding a new Director of the Public and Community Psychiatry Program who met with each resident weekly mentoring them, created a set of didactics for the four years, created "shadowing" experiences with community mental health psychiatrists, created community electives rotations, and built a network of community agencies wanting to hire her graduates. Note that the director began as a newly funded fellow in public and community psychiatry.

At a low cost, MHSA could adopt this model, but in my opinion it is only likely to succeed if there aren't major resistances to pulling residents away from other valued activities. The two strategies could be combined – adding more residents and creating a Public and Community Psychiatry Program – if a program that is already creating large numbers of community mental health psychiatrists was engaged.

2) Train psychiatrists to be more prepared to work in recovery oriented settings without needing retraining.

There have been widespread criticisms of residency programs (e.g. by the Annapolis Conference) for not training residents to be able to work in community settings. Long lists of skills are generated while residency directors generally point to the long list of existing requirements that are already over filling residents' schedules. These requirements are nationally based and not easily influenced by the MHSA. Adding recovery to the mix makes things even more difficult. There's another list of skills (and more importantly values) to master, many of which conflict with the traditional list. Therefore, attempting to just add a few new classes will just confuse residents.

I would recommend adding four modules of combined lectures, experiences, and supervision to prepare residents to work in new recovery based programs. Some existing lectures could probably be integrated into these modules.

1) Recovery
2) Community Resources
3) Healing Relationships
4) Dual diagnosis competency

1) Recovery

This module consists of:

1) The reality of recovery – First person accounts, research studies, recovery celebrations, expectation and belief in recovery
2) The traditions of recovery – 12 Step (attend meeting), consumer movement (self-help, WRAP, Alternatives conference), rehabilitation (UCLA modules, Boston University, supported education and employment, quality of life accountability), staff experience of recovery in their own life, spiritual recovery (Moral treatment history),
3) Understanding recovery – Subjective experience (e.g. Deegan), developmental stages (Ragins), what works: recovery practice and culture (Anthony)
4) Psychiatrist role in recovery
5) Personal transformation into a recovery worker – personal motivations for entering psychiatry, centering your work on your heart, responsibly letting go of care taking, "getting it"

This module should be early in training so that subsequent experiences will be seen through the lens of recovery and then by the end of residency they will have a solid personal belief in, experience of, and understanding of recovery.

2) Community Resources

This module consists of site visits, first person accounts, staff networking, understanding the roles and rules of the resource, and assisting someone to access the resource for:

1) Social security
2) General relief
3) State disability, unemployment
4) Shelters, emergency housing, transitional housing, permanent housing, HUD, landlords
5) Community agencies (Churches, volunteer center, parks and recreation, etc.)
6) Vocational rehabilitation
7) Disabled students' services
8) Legal system (police, courts, probation, parole, jail, prison, juvenile justice, and civil courts)
9) Substance abuse treatment facilities (including prop36)
10) Medical care – County clinics and hospitals, free clinics, MediCal providers and HMO plans, dental care
11) DCFS, child protective services, family reunification, foster care
12) School system
13) Regional centers
14) Transportation – (Bus ID, dial a ride)
15) Elderly services (Senior center, meals on wheels, senior housing, adult protective services)

This lengthy module should also be early in training so residents can confidently and effectively access quality of life supports for their patients, rather than feel helpless or like it's someone else's job. This will help them connect with patients and see their job not as treating mental illnesses, but as helping people with mental illnesses have better lives. (As one resident put it, "I learned how to be a good psychiatrist instead of a bad social worker.)

3) Healing relationships

This module consists of lectures, exercises, clinical supervision, and discussion. These are the same tools we're teaching to new case managers and psychiatrists should be at least as skilled in these areas as the rest of the staff. This could be a multiple-discipline training.

1) Welcoming and Engaging: Engagement techniques – creating trust and belief, "Meeting people where they're at", Charity – giving without expectations, Client vs. friend role – camaraderie – nondefensive, Doing nonclinical things together - enjoying client's company

2) Listening: Avoiding agendas, Creating space in yourself for their story – not just waiting for your turn to talk, Nonjudgmental – depersonalizing /it's not about you, Genuine curiosity and interest – letting them teach you

3) Empathizing vs. sympathizing: Feeling their feelings – reflecting back, Using your life experiences – to find connections, not impose your story, Subjective understanding – seeing the world through their eyes – role playing, Making people feel understood and cared for – keeping them in your thoughts

4) Creating a shared story: Collaboratively learning about them, Asking questions to make a story, Understanding transference

5) Emotional healing: Creating corrective emotional experiences – avoiding retraumatizing, Understanding emotional templates and dynamics, Use and misuse of boundaries

6) Goal visualizing: Uncovering people's strengths, Believing in people until they can believe in themselves, Creating concrete hopeful visions of the future, Storytelling of successful role models, Your goals and expectations vs. their goals and expectations

7) Empowering: Equalizing your relationship, Self-disclosure, Responsibility sharing, Avoiding power stealing

8) Using motivational interviewing / Stages of Change: Increasing their decision making skills, Working in ambivalence, Working in negative spaces (e.g. battered women, addicts) with acceptance

9) Creating a menu of opportunities: Meaningful education and meaningful choices, Create exposure to new opportunities, Share knowledge of array of resources and supports

10) Moving beyond linkage to support: Not doing for, but guiding alongside, Teaching skills while doing together, Modeling problem solving and advocacy, etc.

11) Teaching self-evaluation and self-reward: Self-acceptance while judging, Self-observation (e.g. internal states, functioning, quality of life), Learning from "failures" – getting something good from bad events, Self-praise – internalizing improvements

12) Teaching self-help techniques: Self-care from maintenance to crisis (e.g. WRAP), Symptom relief and re-centering techniques, Self-help groups, self-advocacy

13) Building supportive relationships in the community: Mutuality of relationships – self-disclosure to build consideration of others, Getting support as a byproduct of other activities and shared interests, "Relationship maps"

14) Creating community roles: Teaching and modeling role expectations and behaviors, Finding repetitive, regular activities with personal connections, Finding "welcoming hearts" in the community, Creating belonging

15) Providing spiritual/existential guidance: Finding meaning in suffering, Uncovering "core gifts", Finding a "higher purpose", Relating to a "higher power"

Note that some of current "psychotherapy" training could be integrated into this module, but that other parts are contradictory and we'd have to explain why the techniques and rules are different in different settings and therapeutic cultures.

This module would probably be a prolonged module across a number of different clinical services.

4) Dual diagnosis competency

This module consists of:

1) Assessing dual diagnosis – Biological effects, emotional effects, patterns of use and abuse, stage of recovery (NIMH- engagement, persuasion, active treatment, relapse prevention, Minkoff, and 12 step)
2) Substance abuse recovery relationships – our emotional reactions to substance abusers, internal bias and stigma, welcoming, creating a "counterculture of acceptance", persisting through frustration, accepting our own powerlessness, grieving, "hospice" caring not curing, sponsors
3) Substance abuse treatments – stage specific interventions, harm reduction, motivational interviewing, "raising the bottom", working a 12 step program, self-help and groups, role of medications
4) Dual diagnosis treatment resources and systems – integration of care, not "exceptions" to be sent to specialty program elsewhere, (Minkoff)

This module is a more advanced topic. Residents have to be highly skilled at recovery, healing, and biological diagnosis and treatment to move effectively into this area. On the other hand, it is crucial that they do move effectively into it rather than avoid it. Dual diagnosis competency is essential to help the majority of our most difficult patients and for our transformed system to succeed.

3) Transform psychiatric residency programs themselves to be an integral part of the new transformed system of care.

Over the long run if the entire mental health system is going to be transformed, psychiatric residencies themselves must be transformed. Several difficulties exist in the structure of our present programs that would need to be addressed.

Our present residency training generally begins in inpatient settings and overall includes a great deal of inpatient training – one full year out of four. When this system was established hospitals were much more common, stays were longer, and the patients more varied including both voluntary and involuntary patients. Hospitals may have been a good place to build a treatment relationship and experience clinical courses in a supervised environment. Now hospitals tend to be extremely short stay, involuntary, frustrating, revolving door settings. In my harsh judgment, our acute hospitals are the most coercive, dangerous, frightening, fragmented, dehumanizing, traumatizing, diagnosis and documentation driven, overmedicating part of our public mental health system. Spending a lot of our most formative times in these settings is undesirable and probably impacts how we act later on. Many of these traits are precisely the same ones psychiatrists are routinely criticized for.

Our programs are often in academic or hospital based centers rather than community based. These centers may be overly staffed with professionals with minimal direct patient care responsibilities. They are often parts of large hierarchical organizations that feature numerous barriers to care. They often take pride in other parts of their programs over community service and may be seen as distant, aloof, and irrelevant by their communities. Conversely, residents don't learn to value and create "natural" community and family support system relying instead on the world within the institution. Community discharge planning skills are rarely developed. Exposure to self-help, peer advocacy, and consumer employment are almost nonexistent.

Our programs are often tertiary referral centers where residents are exposed to a distorted view of the severity of illnesses and the need for extreme, coercive treatments. Residents see people only at their worst and only within illness based environments. Continuity of care is not emphasized and residents rarely get a good view of the long term course of treatment and hopeful recoveries.

Here is my proposed transformed psychiatric residency program:

Year 1 (internship):

- 4 months medicine
- 2 months neurology
- 2 months "community engagement" setting (triage, walk-in clinics, outreach and engagement, mobile outreach, etc.) where people are welcomed into the system
- 2 months intensive community support services (ACT, ISAs, AB2034, etc.) where people with serious disabilities are supported long term in the community.
- 2 months community "self-directed" / "graduation" settings (Wellness centers, self help settings) where people are directing their own treatment and leave the system.

Didactics: psychopharmacology, consumer and family perspectives, relationship building – especially engagement skills, recovery basics, team work.

Year 2:

- 12 months outpatient in a CMHC clinic setting where there is long term continuity of care. (I would virtually dismantle the existing university / hospital-based clinics and integrate the staff into existing CMHC clinics.)

Didactics: continue Year 1 topics, psychotherapy theory and practice, rehabilitation / supported services, community integration, substance abuse.

Years 3 and 4 (specialty topics):

- 2 months inpatient
- 2 months crisis setting (ER, crisis center, mobile crisis team, police crisis team, etc.)
- 2 months substance abuse treatment
- 2 months geriatrics (include hospice experience)
- 4 months Consultation and Liaison (include community medical care collaboration experience)
- 2 months forensic (jail, parole, forensic hospital, conditional release outpatient, etc.)
- 4 months Child and Adolescent in a CMHC setting (include school, foster care, developmental disabilities, and juvenile justice experiences)
- 2 months Administration / Finances / Leadership (include history of community mental health, public and private funding systems, program and community leadership, public education and anti-sigma experiences)
- 4 months elective

Didactics: accompany each rotation

Note: Child and Adolescent psychiatrists intending to go on a 5th year will substantially expand Child and Adolescent rotation and take most of their specialty topic rotations in Child and Adolescent settings.

I think that this design would better prepare and recruit psychiatrists for multifaceted community mental health careers while also fulfilling the educational needs of other settings. It would also integrate psychiatrist into the community mental health system and facilitate the kind of community based / service delivery research we desire. The distance between innovation and practice would shrink drastically.

I am aware that this proposal requires changes in accreditation and board certification rules, but if we are to achieve true transformation we should be figuring out how to change things to get things done rather than deciding what can't be done because it would require change.

There is bound to be substantial resistance to transformation on this scale. There are old mistrusts and wounds and defensiveness to overcome as well as giving up things we like and are comfortable with. However, if psychiatry wants to demonstrate it truly wants to re-embrace community mental health, if it wants to be included as an active transformational partner instead of overcome as an obstacle, this would be a compelling plan.

There may be some residency program willing to become a model for full transformation. It is likely they could get substantial MHSA funds if they were to make a total commitment and maybe special

wavers from accreditation. If they succeeded, they would stand to gain a great deal of status, prestige, and nationwide attention.