Mentoring, Supervision, and Consultation in Community Mental Health

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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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H.L. McQuistion et al. (eds.), *Handbook of Community Psychiatry*,
DOI 10.1007/978-1-4614-3149-7_49,

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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