# Progress in Workforce Development Since 2000: Advanced Training Opportunities in Public and Community Psychiatry

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**A crisis in the behavioral health care workforce has drawn considerable attention from consumers, families, advocates, clinical professionals, and system administrators at local, state, and federal levels in the past decade. Its effects have been felt in the recruitment, retention, and performance of psychiatrists in the public sector, where a focus on biological aspects of illness and efforts to cut costs have made it difficult for public psychiatrists to engage meaningfully in leadership, consultation, prevention, and psychosocial interventions. An array of training opportunities has recently been created to meet the needs of community psychiatrists at various stages of their careers, from psychiatrists just beginning their careers to those who have been working as medical directors for several years. This article describes the development of these initiatives and their impact on public psychiatry in four key areas—training of experienced psychiatrists, ensuring retention of psychiatrists in community programs, providing fellowship training, and creating professional identity and pride. Although these programs constitute only initial steps, opportunities for psychiatrists to obtain advanced training in community psychiatry are much greater now than they were ten years ago. These initiatives will enhance the professional identity of community psychiatrists and provide a solid foundation for future development of public service psychiatry in the behavioral health workforce. (*Psychiatric Services* 62:782–788, 2011)**

We have just completed a tumultuous decade for behavioral health care in the United States. Even before the decade began, awareness was increasing that we had not been adequately meeting the needs of persons with mental illnesses and addictions. By 2000, there was growing recognition of a crisis within our nation's behavioral workforce, including psychiatrists, working in the public sector. Both the training and the supply of behavioral health workers were inadequate. As these deficiencies appeared to become even more critical, the call for significant reform grew louder (1).

Having come through this period, the new decade promises to bring significant change to our systems of care. Leaders in the field, including the American Psychiatric Association (APA), the American Association of Community Psychiatrists (AACP), the American College of Mental Health Administrators (ACMHA), and the National Council on Community Behavioral Healthcare (NCCBH), have brought attention to the problems in public psychiatry and articulated goals for improvements. An array of training opportunities has recently been created to meet the needs of community psychiatrists at various stages of their careers. Clearly many more opportunities are in place for board-educated, board-certified psychiatrists to obtain advanced training in community and public psychiatry at the close of the decade than were present in 2000.

## Changing roles in public psychiatry

In 2001 the Annapolis Coalition on the Behavioral Health Workforce was convened to improve the recruitment, retention, training, and per-

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formance of the prevention and treatment workforce. Developed by ACMHA with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), the coalition, a not-for-profit organization, has facilitated strategic planning on the workforce crisis by advising federal agencies on workforce issues and providing technical assistance to states and nonprofit organizations. Following a two-year strategic planning process, the Annapolis Coalition completed an action plan identifying seven goals for broadening, strengthening, and supporting the behavioral health workforce (2) (see box on this page).

The goals in that report had special relevance to the role of psychiatry, which had experienced significant changes over the past two decades (3,4). Tremendous advances in our scientific understanding of the brain, pharmacology, and the biological processes contributing to behavioral health disorders were made during this period and embraced by psychiatry, creating a sense of excitement and hope that people could overcome the symptoms of mental illness (5). At the same time, a variety of forces emerged to limit the focus of psychiatric practice to the biological aspects of illness, reducing psychiatry's role in leadership, consultation, prevention, and psychosocial interventions. The increasing costs of care created new pressures from payers and mental health service organizations to reduce expenses (6), adding to psychiatrists' caseloads and limiting the time they had to engage in building relationships with their clients (7,8). Concurrently, psychiatric residency training programs began to focus a greater portion of their curricula on the biologic aspects of illness, leaving psychiatrists less prepared to contribute in other ways. Research initiatives in community psychiatry have had difficulty translating science to service programs, limiting their potential to support a broader role for psychiatry (9).

The skill set of the psychiatric workforce was further challenged by the rise of the consumer, or recovery, movement, which had been gaining strength and direction over the prior 15 to 20 years. The recovery movement, which stresses self-management of health and illness and hope for a satisfying life in the community (10,11), requires a different kind of relationship between consumers and psychiatrists, one that would realign the balance of power (12). Recovery also asserts the need to look beyond symptoms and service use for indicators of capacity and well-being. The principles of this movement were given legitimacy by the President's New Freedom Commission report (1,13). The report, issued in 2003, called for transformation of the behavioral health system in order to emphasize the central role of service users in driving their own treatment. It identified six goals, including ensuring that Americans understand that mental health is essential to overall health; that mental health care be consumer and family driven; that disparities in mental health care be eliminated; that early mental health screening, assessment, and referral to services be common practice; that excellent mental health care be delivered and research accelerated; and that technology be used to access mental health care and information.

Against this backdrop, AACP convened a conference in Pittsburgh in March 2006 to address the challenges of transforming the system of care. The conference, entitled Keystones for Leadership and Collaboration: Transforming Community Psychiatry, attracted nearly 100 psychiatrists, 100 consumers, and 200 allied behavioral health professionals. Thirty-five topical discussion groups and six consumer-provider dialogues held over the two-day meeting provided primary input for a draft report of recommendations. Additional suggestions by AACP members and other stakeholders from across the country were incorporated into the report, which was finalized in 2007. Key recommendations are presented in the box on the next page; the full report can be reviewed at www.communitypsychiatry.org.

Several major initiatives have emerged since 2007 that are consis-

### *Action plan of the Annapolis Coalition on the Behavioral Health Workforce: strategic goals at a glance*[a]

**Broadening the concept of workforce**

Goal 1

Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

Goal 2

Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

**Strengthening the workforce**

Goal 3

Implement systematic recruitment and retention strategies at the federal, state, and local levels.

Goal 4

Increase the relevance, effectiveness, and accessibility of training and education.

Goal 5

Actively foster leadership development among all segments of the workforce.

**Structures to support the workforce**

Goal 6

Enhance the infrastructure available to support and coordinate workforce development efforts.

Goal 7

Implement a national research and evaluation agenda on behavioral health workforce development.

[a] Based on *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion* (2)

### *Key recommendations by the American Association of Community Psychiatrists for transformation of community psychiatry*[a]

**Recommendations for the psychiatric profession**

Provide integrated assessment and planning for individuals informed by the multiple influences of environment, including culture, spirituality, gender, race, sexuality, occupation, and age

Define the roles of the psychiatrist in the community, incorporating concepts of advisor, interpreter, teacher, student, partner, confidant, and healer

Develop advocacy agenda, both accommodative and transformative, based on public health and preventive medicine principles to address health disparities and aid distressed communities

Create a research agenda relevant to clinical practice that encourages innovation, flexibility, investigation of positive deviance and experientially successful practices

Create professorships and fellowships in community psychiatry with clear support from academic departments and a variety of public and private sources

Establish tracts for trainees with public service interests with enhanced mentoring, clinical experience, and scholarship

Identify and recruit potential psychiatrists with public health interests early in their training through the creation of a supportive professional community

Incorporate recovery-enhancing practices in all training experiences and emphasize the development of skills for effective engagement and collaboration with service users in the planning process

Support an emphasis in training on the development of skills and knowledge essential for leadership, such as group therapy, family systems therapy, clinical team activities, economics of health care, service system planning and management, evaluation, and consultation

Provide training experience in primary care settings in consultation with primary care physicians and in management of uncomplicated physical health problems in psychiatric settings

Emphasize prevention, creating rational systems of care, and building resilience among individuals and communities

Develop integrated systems of care that incorporate unified approaches to individuals with multiple and diverse needs

Provide consultation to clinical teams, behavioral health agencies, and larger systems of care

**Recommendations for individual psychiatrists**

Embrace principles of a recovery-focused practice, giving priority to clients' individual needs

Incorporate nonjudgmental, motivational, hope-inspiring therapeutic approaches and change management techniques into practices

Facilitate consumers' involvement in selecting the services they want in the context of available resources

Focus on strengths, hopes, and autonomy in developing recovery partnerships and collaborative planning arrangements

Ensure that planning processes are determined in the context of individual cultural and spiritual influences and that they are sensitive to traumatic experiences

Create bridges between disparate treatment cultures (for example, addiction and mental health) using the recovery paradigm as a unifying principle to integrate services

Develop the relationships necessary to facilitate integrated care across systems of care

Develop person-centered treatment planning processes for application in diverse treatment settings

Provide evidence-informed clinical practices, including circumstance-specific evaluation and service improvement

Support opportunities for consumers to develop skills as peer counselors, to be employed in these roles, and to be incorporated into the clinical team and administrative processes

Promote practices that will enhance the health of communities and the stability of families

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

Promote public health and prevention activities

Provide opportunities to discuss social policy and justice on a variety of controversial issues, such as abortion, impact of war, end-of-life rights, and capital punishment

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tent with the recommendations of the conference on transformation. In the remainder of this article, we describe the development of these initiatives and their impact in four key areas of public psychiatry—training of experienced psychiatrists, ensuring retention of psychiatrists in community programs, providing fellowship training in public and community psychiatry, and creating professional identify and pride.

## Training for experienced psychiatrists

Psychiatrists who work in community settings for significant portions of their careers often find themselves in at least nominal leadership positions as medical directors of the organizations where they work. The level of authority and responsibility that these positions carry varies considerably, influenced, at least in part, by the capacity of the psychiatrist to contribute to administrative and leadership processes. Although there are other significant influences on this determination, those who bring valuable skills to these positions are much more likely to be influential within their organization (14). Yet the development of such skills has diminished within residency training programs, and psychiatrists often find themselves unprepared for leadership.

Recognizing the need to enhance the capabilities of psychiatrists in community settings, the National Council on Community Behavioral Healthcare, with financial support from SAMHSA's Center for Mental Health Services (CMHS), worked with leading members of AACP and others to develop the Psychiatric Leadership Development Program (PLDP). A basic curriculum was developed in 2007, and the first class was convened in 2008. The PLDP is designed to enhance the knowledge, skills, and abilities of psychiatrists who serve as medical director in a community behavioral health organization (CBHO). The program aims to enhance the professional satisfaction of psychiatrists by equipping them with knowledge of the public mental health system, by teaching them specific skills in administrative psychiatry, and by coaching them in organi-

zational leadership. Those who have access to these opportunities have been shown to have greater job satisfaction and to be more likely to continue in their positions (15,16).

Application to the one-year program requires the written support of the CBHO's executive director, and acceptance decisions are managed by National Council staff and course faculty. The curriculum covers an array of topics commonly included in established leadership development programs (17,18). Participants engage in didactic, experience-based, and online learning opportunities. Individual coaching and consultation are available to support learning and create a social network. Faculty comprises consultants from the not-for-profit business sector and community psychiatrists, most of them on the AACP board of directors. Participants are engaged as members of their organization's executive leadership team and allowed to make valued contributions to its activities. The program, now in its third year, has graduated 25 physicians, and plans are under way to maintain an active alumni group.

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**Recommendations for service systems and communities**

Create cultures of inclusion that value all inputs (including psychiatrists and consumers) and actively seek them
Embrace recovery principles and enhance support for the psychiatric rehabilitation model, stressing resilience, productivity, and creativity or "capacitation"
Define the role of psychiatry in clinical and administrative activities and ensure that they are used accordingly
Create opportunities to free psychiatrist's time through physician extenders, use of primary care providers, and supervisory relationships
Develop workforce (nursing, social work, and psychology) in addition to psychiatry to work collaboratively in mobile services, by telephone, through Web-based consultation, and in clinical teams for most efficient use of resources
Encourage simple, evidence-informed prescribing practices with a focus on relationship building and incorporation of nonpharmacologic interventions
Develop and use clinical tools that are interactive and support equity in services and recovery-focused practices
Create quality cultures through training in quality management principles throughout the workforce, grassroots participation, and incentives rewarding excellence
Develop collaboratives that build on the strengths and wisdom of communities, providing support and advice to empower them
Raise awareness of civic processes and how to effectively create influence over public policy
Promote public health and prevention perspectives and develop partnerships with communities to promote health
Create dialogues or town meetings devoted to issues related to behavioral health of individuals and communities

[a] Based on the report from a conference convened by American Association of Community Psychiatrists in March 2006 called Keystones for Leadership and Collaboration: Transforming Community Psychiatry (9)

## Retention of psychiatrists in community programs

Psychiatrists who are recruited directly into medical director roles early in their careers are often not well prepared for them. They often decline such positions, particularly if they are not offered assistance in acquiring skills needed to perform them adequately. Sometimes psychiatrists in clinical positions in community settings are encouraged to take on medical director functions without adequate preparation or support (19). Agencies in underserved areas have little to offer to these candidates to assist them with career development. As a result, psychiatric clinicians are pressured to assume administrative functions, often without having had their clinical responsibilities reduced. In some settings, agencies may have a nominal medical director but not have any intention to use that individual for leadership or administrative activities and not realize the added value that meaningful medical director functions bring to an organization.

These psychiatrists are the focus of the Community Psychiatric Practice Mentorship Service (CPPMS), a program organized by AACP in collaboration with several national mental health organizations. CPPMS provides mentoring and psychiatric organizational consultation to CBHOs referred by the national mental health organizations, allowing them to enhance their capacity to recruit psychiatrists and to provide satisfying roles for them within their organizations. It also provides a mentoring opportunity for these psychiatrists to master essential skills that will allow them to add value to their organization. Seasoned community psychiatric leaders serve as mentors and consultants in the program.

The CPPMS mentor works as a consultant with a CBHO for one year. The consultant makes an initial site visit in order to gain familiarity with the agency and its psychiatric staff, after which mentorship is provided through long-distance communication. The mentor engages with one or more psychiatrists to provide training and support in a format that focuses on experiences encountered on the job. The mentor may also work with psychiatric and other agency leaders to identify organizational issues that both agree could benefit from consultation, such as implementation of integration of behavioral health with primary care, co-occurring disorder treatment programs, or creative ways of developing a work environment and job descriptions that provide opportunities for professional growth and facilitate staff retention. These consultation activities are negotiated with the participating CBHO, which develops a mentoring and consultation plan.

CPPMS provides another useful model for supporting the growth of well-rounded community psychiatrists. Agencies operating in underserved areas have struggled with recruitment and retention. The program's cost is a relatively small investment compared with the costs of having an ineffective medical director or,

### *Elements of fellowship program design*[a]

**Core elements**
Academic or didactic curriculum
Primary field placement
Faculty supervision and mentoring
Teaching, presenting, and supervising
Research or quality improvement project

**Elective elements**
Systems management skills
Community, consumer, or family advocacy
Recovery- or resiliency-oriented services
Cultural competency, sensitivity, and health disparities

[a] Based on guidelines developed in 2008 by the American Association of Community Psychiatrists (25)

worse, with the costs of replacing psychiatrists who leave because of lack of support or dissatisfaction with being wedged into ever more limited roles. CPPMS might be seen as a sort of "insurance" for the retention of psychiatrists.

Another program designed to improve skills and broaden the roles of early- and mid-career psychiatrists is the Transformational Leadership in Public Psychiatry Academy. The program was developed by APA in collaboration with SAMHSA on the basis of the literature related to transformational leadership principles in the mental health field (20–22). It was started in 2009 to equip ten psychiatrists working in community settings to become agents of change in the public mental health system. Mentoring and case-based learning are core elements of the academy experience. Each fellow develops a project related to systemic change, and developing strategies to make the changes work provides rich opportunities to interact with mentors and other fellows.

Recognizing that diversity is a critical aspect of developing future leaders, the program has created opportunities for members of underrepresented minority groups to participate as fellows. Six of the ten psychiatrists who constituted the academy's inaugural class were previously recipients of APA's public psychiatry fellowship or the APA–SAMHSA minority fellowship.

## Fellowship training in public and community psychiatry

Advanced postgraduate training in public and community psychiatry has been available in some form for more than 40 years. Many fine programs were implemented during this period, but most were relatively short-lived, having disappeared for lack of sustainable funding or sufficient interest from potential applicants.

The singular exception has been Columbia University's public psychiatry fellowship. This program has been operating continuously with state funding since its founding in 1981, graduating ten fellows annually (23). Its success is well documented—95% of alumni have continued to work in the public sector, and about 65% have assumed leadership roles. Until recently only two other programs (at Yale and Emory universities), both smaller, had emerged to provide fellowship training in this field. In the past three years, however, in a rebirth of interest, new programs have begun at the University of Pennsylvania, the University of Pittsburgh, Lake Erie College of Osteopathic Medicine, New York University, the University of Florida, and the University of Texas Southwestern Medical School. In addition Case Western Reserve University has revived its program after several years of dormancy, and at least three new programs, in Orange and San Diego counties in California and at Oregon Health Sciences University, are in development. Even though most programs have capacity to train only one to three fellows annually, they represent a dramatic increase in both the number and the diversity of training opportunities over a short period (24).

Faculty at Columbia University identified a set of seven core elements for developing programs in 2007 (23), and many new programs consulted with the Columbia program in developing their curricula. The publication of the Columbia core elements and the renewed interest in developing fellowship programs inspired AACP to begin preparing a set of guidelines for developing and evaluating public and community psychiatry training fellowships, which were completed in 2008 (25,26). This document creates 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. The elements needed to support this vision in training programs and to once again establish psychiatry's strong position in leadership and consultation are laid out in the guidelines (see box on this page).

## Creating professional identity and pride

A significant barrier to developing the psychiatric workforce in public and community psychiatry has been an ill-defined skill set and a lack of recognizable activities and expertise associated with this special field of work. Too often the vibrant, challenging, and rewarding aspects of community psychiatric practice have been lost due to unimaginative job descriptions, a reductionist view of psychiatry, and failures to properly train public psychiatrists for leadership. The critical need for psychiatrists in the public sector has yet to be reflected in compensation, lifestyle accommodations, or broader definitions of psychiatrists' roles. Isolation, heavy caseloads, and limited opportunities for career development have often resulted in burnout and the inability of agencies to retain psychiatrists over the long term.

The state of Pennsylvania has developed an agenda to address the

shortage of psychiatrists choosing and remaining in public and community psychiatry through the formation of three centers of excellence. The centers provide not only fellowship training opportunities but also a platform for addressing issues related to poor retention. Through the creation of networks of provider agencies, and the psychiatrists who work for them, each center provides opportunities for communication and consultation, mostly through electronic means, which reduce the sense of isolation that many psychiatrists have felt. Continuing medical education is provided through the Community Psychiatry Forum, a seminar series in a videoconferencing format that was developed in association with AACP. It is also part of the fellowship programs' curricula in the state. Provider network members have an opportunity to learn and teach in the context of the fellowship training programs. In addition, an annual conference is organized to allow psychiatrists to meet their peers face to face, making electronic relationships "real."

The faculties of the centers—primarily the program directors—offer consultation and support to psychiatrists negotiating positions with their agencies and to agencies attempting to make their work environments more attractive to potential candidates by exploring creative ideas about the use of psychiatric resources. Whereas the Pennsylvania response was tailored to meet the particular needs of that state, it creates a continuum of training and engagement opportunities for psychiatrists at several stages of their careers that is of heuristic value to others hoping to address similar circumstances.

With a goal of bolstering professional identity of community psychiatrists, AACP has begun a process to provide certification to those who have demonstrated that they have achieved the competencies set forth in its guidelines for developing and evaluating fellowships in public and community psychiatry (25). The impetus behind developing a certification process has come from the trainees considering careers in public and community psychiatry; many of them feel that certification would provide a way to recognize expertise in the field and encourage others to enter it. Questions remain about how to determine eligibility for certification and how to best measure competence, but an examination is under development and may be administered as early as 2012.

APA and AACP have recently formed a partnership to administer a five-year "research to practice" grant awarded by SAMHSA. The object of this project is to develop curricula to train psychiatrists at all phases of their careers to incorporate principles of recovery-oriented care into their practice (26). These principles, which include collaboration, shared decision making, inclusion, and the development of natural supports and autonomy, are at the core of what defines community psychiatry and will thereby expand the degree to which the workforce is equipped to meet the challenges of the future.

The initiatives outlined above, while significant, only begin to address all of the steps needed to develop and support the psychiatric workforce. It is critical to effectively encourage the interest of residents and students in the early years of training. It is important to note that although residency training programs in community psychiatry, such as those of Oregon and Ohio (27,28), are not the subject of this article, they all must rely upon solid faculties to support them. Without enough adequately trained and enthusiastic psychiatrists working in community settings and training programs, it will be difficult to attract and prepare the next generation.

Even mentoring or networking fellowships, such as APA's public psychiatry fellowship, have a significant impact. Those participating in the program frequently assume roles of leadership within the profession, and many are involved in training and mentoring future psychiatrists. Yet, although the program has been an exceptional experience for those who have participated, it has room for a relatively small class of ten residents annually. Much needs to be done to expand access to this type of experience and nurturing.

## Conclusions

The need to improve recruitment, retention, and performance in public service psychiatry has never been greater. With the initiatives described above, the field has begun to respond, but more must be done to ensure that the psychiatric workforce can meet the challenges of the present and those that lie ahead. It is critical to develop not only the content and form of training opportunities but also sustained support for them. Academic departments of psychiatry must be persuaded of the value of supporting the activities of community psychiatry and of giving it higher priority on the training agenda (29).

States can have a significant impact in this regard—substantial experience shows that states that have supported the training of public service psychiatrists, both at the fellowship level and at the residency level, have realized ample returns on their investments, primarily by retaining psychiatrists in the region in which they have trained. Many programs have disappeared for lack of such support. A broad base of community support from multiple stakeholders would further solidify the stability of training programs.

Significant progress has been made toward meeting the needs for psychiatric workforce development in the 21st century, as the programs and activities described above demonstrate. Through the various new training and support opportunities now available to psychiatrists beyond their general training, further progress can be expected. Momentum can continue to build through the addition of programs now in development, and it appears that these beginnings will provide a solid foundation on which to build.


### *Acknowledgments and disclosures*

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