

# Community Psychiatrist

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## President's Column Reconciling Opposites



This year's Nobel Prize in physics was awarded for showing that the universe is expanding with increasing acceleration, even if we don't really know why. Here on Planet Earth, in the mini-universe of community mental health, we're on the cusp of something that draws opposing forces –expansion in the face of contraction. As western economies undergo stress and a threat of double dip recession looms, community based behavioral health, and specifically community psychiatry, will become more prominent.

In the United States political ideological combat is causing mythic gridlock on debt management while constituencies are clear about wanting pragmatic compromise (85% in a recent CBS-NYTimes poll). In the near term at least, as with most other funding, healthcare, and specifically, behavioral health, will need to manage under a much tighter belt. Nearly everyone agrees that these costs must come down – some call it "bending the cost curve." But how and where?

Many of us reading this already know that critical service trends that are aligning to shape this. There are two prime examples. The first is data-driven service. A timely culture byte: if you've seen the film *Moneyball*, you'll know that its protagonist moves to change how baseball teams are assembled, but on a shoestring, using statistical analysis as a catapult to success. While the business community has now been doing it for years, it's only dawning in our universe. Our exemplars are high utilizers of care –those who account for a grossly disproportionate share of costs. It makes clinical sense to engage them into eventually less expensive, less crisis-driven, modes of care. Funding will, in turn, be driven by "pay for performance," a term already well conceptualized on public policy levels.

A second key trend is integration of primary care and behavioral health. This year's APA Institute for Psychiatric Services theme (with Wes Sowers as Chair of

its Scientific Program Committee and John Oldham as APA President) is 'Comprehensive and Coordinated Care.' We know that closely coordinating primary care with psychiatry, and vice versa, should yield better engagement, especially for marginalized populations, and hopefully give people improved wellness outcomes. That should help bend that cost curve.

But these trends require *adaptation*. Adaptation will likely comprise contractions in structures many of us in psychiatry hold dearly; particularly traditional office based private practice and the ascendant position of the general hospital in service provision and as superordinate training site. Clinical administrators will also now really be held to show positive outcomes and fiscal solvency (aka Mental Health Moneyball), requiring us to be much faster on our feet.


There will be pain and some will say that patient care will be categorically compromised, but danger has always been there in the struggle of "people versus money." The funding portal will be narrower and financing will use different rules –and in modified service environments: community clinics such as Federally Qualified Health Centers, in learning to work literally side-by-side with primary care colleagues, and educating trainees soon working in these environments, too.

I believe that where community psychiatrists enter is actually in a good place. Community psychiatrists have always been among the most adaptable professionals. We're able to work in shelters, in disaster areas, on Indian reservations, on mobile crisis teams, just to note a few. The expertise we offer is of being systems-savvy.

So here's what will actually expand, as everything seems to contract. Our ability to be flexible will achieve higher valence and we will be in greater demand. We will be called on to supervise and educate mental health professionals, particularly psychiatric residents, as ACGME "systems-based competency" receives greater attention. We are poised to be called on more often to lead service delivery systems.

However, in order to maintain poise, we need to stay ahead of the expectations curve. AACP will help. Identified credentials in

specific expertise areas will be increasingly important and in order for community psychiatrists to position themselves, our efforts to formulate and execute a certifying examination in community psychiatry must continue, and with appropriate resources. This will be a key step in the development of our subspecialty. A pending *Handbook of Community Psychiatry*, endorsed by the AACP and the first such volume in at least 10 years, will also assemble the discipline's fund of knowledge, creating an important piece of community psychiatry's contemporary foundation. Lastly, visibility is important. We all need to take any opportunity to make ourselves known in our local communities and the AACP will find ways to continue to work on national visibility. A good current example is our involvement, together with APA, in the SAMHSA-funded Recovery to Practice initiative. This is how we can continue formulate and do expansive work. Finally, and speaking for the Board, we are intensely interested in feedback from all members to help this process advance. I look forward to your thoughts at IPS's Membership Forum on October 28th in San Francisco.

  
Hunter L. McQuiston, M.D.  
President, AACP

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Dear AACP Members,

Welcome to the fall issue of *Community Psychiatrist*, the AACP's newsletter!

This issue outlines the academic advances in community psychiatry workforce development and training.

As the national demand for psychiatrists increases without a matching increase in supply, the need to increase the number of psychiatrists prepared to meet the needs of publicly funded mental health programs is being addressed by the creation of Public and Community Psychiatry Fellowships.

Public and Community Psychiatry Fellowship programs have been expanding throughout the country. The first fellowship was founded in 1981 at Columbia University's New York State Psychiatric Institution. There are currently 15 programs, most of which have developed over the past five years.

The goal of these programs is to prepare psychiatrists for leadership roles in publicly funded organizational settings.

Public and Community Psychiatry Fellowships provide training in psychiatric leadership, recovery oriented services, advocacy, mental health administration and program evaluation/services research. These one to two year post-residency fellowships provide a combination of didactic and field experiences with a strong emphasis on mentorship from other community psychiatrists. Fellows are exposed to a variety of practice environments within community psychiatry.

Emory University's Director of Fellowship in Community Psychiatry and Public Health Raymond J. Kotwicki, MD, MPH states that his program "has been training future leaders in psychiatry since 2001. As part of our training program, fellows are required to earn an MPH over two years while concurrently providing clinical, programmatic development and political advocacy services within the community. We do not believe that 'community psychiatry' is synonymous with 'public psychiatry'; rather, the notion of community psychiatry provides a model of combining the best of seemingly disparate philosophies to bolster mental health work.

"We believe that community psychiatrists combine the medical model with the public health model; prioritize social justice equally with individual patient care; conceptualize a transformed mental health system locally and nationally. To this end, our graduates have gone on to become leaders of innovative and transforming programs in mental health."

Jules Ranz, MD, the director of the Columbia University Public Psychiatry Fellowship, is now administering a survey of current and former fellows among the 15 public/community psychiatry fellowship programs.

One facet of the survey is intended to assess the impact of fellowship training on respondent's careers. One respondent replied that "the fellowship has given me confidence in working with patients with a wide range of economic and social difficulties. It also broadened my understanding of resources available to patients, and how to work within systems in order to provide effective care."



Tony Carino, MD, a Columbia Public Psychiatry Graduate, who currently works as a psychiatrist at the Project for Psychiatric Outreach to the Homeless in New York, added that "Public Psychiatry Fellowships provide opportunities for psychiatrists to obtain specific clinical training, supervision, peer support and management skills to navigate the public mental health system and to best serve consumers in community settings."

Beyond training, one must consider the ways in which community psychiatry fellowships benefit the local communities that they serve.

Michael Compton, MD, MPH, prior Co-Director and Fellowship graduate, responds that "although community psychiatry fellowships are designed primarily for the benefit of psychiatrists seeking specialized training in public psychiatry, the universities that house them -- and the larger communities into which they are embedded -- may benefit substantially as well. For example, such fellowships bring focused attention to local public mental health services, and they bring fellows who are eager to learn through gaining practical experience in program development, advocacy, and policy enhancement in those services."

Wayne L. Creelman, MD, MBA, DFAPA, and Director of University of Florida Fellowship in Public Psychiatry adds that "Our Fellow at the University of Florida has been able to bridge the gap for many of our patients by seeing them at a variety of venues to offer a more comprehensive treatment of the psychiatric difficulties. This has led to better care and it keeps folks out of the hospital."

I hope you have enjoyed this overview of Public and Community Psychiatry fellowships. These programs benefit both the future leaders of community psychiatry as well as the communities they serve.

This issue may inspire you to participate as a mentor, consultant or resource in a fellowship program in your region.

For further information, guidelines and publications please follow the link to the AACP Website: <http://www.communitypsychiatry.org/training/fellowships.aspx>

Additionally, there will be a meeting of fellowship directors, trainees and applicants at the IPS in San Francisco:

**Public & Community Psychiatry Fellowship  
training programs meeting**

Thursday, October 27th from 3:30 to 6 PM

Location: Foothill F, Second floor, Marriott Marquis, IPS

Prospective applicants are welcome to attend the entire program, but are particularly encouraged to attend the last hour during which, they will have a chance to meet individually with program directors.

Please refer to page 10 for a list of current programs.

# Taking Strengths Seriously

by Mark Ragins, M.D.



I've often talked about doing strengths-based work, but until recently I didn't seriously try to build my understanding of or skill in doing strengths based work. I more or less assumed that if I found things I liked about a person, described a few positive traits, didn't focus on their barriers and deficits, and nurtured hopefulness that I was being more or less strengths-based. Unfortunately, over time I've found that while the first two are usually relatively easy, the third one is almost impossible since I, like most people, naturally gravitate towards fixing what's wrong, and the fourth depended on my mood and how frustrating the person is.

As I've investigated strengths-based approaches, I've found four paradigms that seem promising to me: 1) social determinants of health, 2) protective factors, 3) self efficacy, and 4) building resilience by finding strengths in struggles. This article describes my impressions of these four approaches and then tries to put it together into a serious service plan.

## Social Determinants of Health

There has been a lot of research that has demonstrated substantially different outcomes from the same illnesses depending on the social situation of the patient. For example, someone with health insurance in a wealthy country is likely to have a much better outcome from treatment for an infection than someone from a poor country who is malnourished and has no access to antibiotics. This is also true for mental illnesses. Some differences seem obvious and some such as people with schizophrenia who are from third world countries have better outcomes than those from developed countries seem counterintuitive and should lead us to considering less obvious social factors.

### Social determinants of health

- Poverty
- Segregated housing
- Diminished social network
- Incarceration
- Family
- Spirituality
- Racial bias
- Political disenfranchisement
- Victimization – abuse, trauma
- Accessibility to health care
- Health seeking behaviors and self stigma

While public mental health providers may say we're treating the "sickest of the sick" far more often we're really treating the "poorest of the sick" or more precisely the people with the worst social determinants of health. How much more effective would our services be if we worked to improve the foundation people are standing on too?

Certainly from an "in the trenches" clinical perspective, it's obvious that people who are poor, uninsured, struggling to survive on a daily basis, and being actively victimized regularly don't engage well in services or recover from their illnesses unless something is done to get them off the streets, out of jail, on benefits and in a safe environment. Our service plans should actively reflect that reality. What if those factors, or a similar list, were overtly included in our initial evaluations and people's initial goals?

It makes me wonder how much of the Village's success is due to building these strengths without us realizing it. When we help people get income, insurance coverage, IDs, legal immigration status, scattered site housing, advocate for themselves within the community, reunite with families, and reconnect with their spiritual faith... are we actually making them more healthy? The likelihood is that the more we help people build strengths in these areas the more effective their treatment would be.

## Protective Factors

I first heard about protective factors from Carl Bell, a black, activist child psychiatrist from Chicago. He showed us two graphs. The first one showed, not surprisingly, that children who are exposed to more "risk" for example parental substance abuse and mental illness, violence, physical and sexual abuse, removal from families, etc have more mental illnesses and symptoms. Then he said let's look at a graph of just children with protective factors. This time the line was almost flat. In other words, if children had protection, they could endure risky events without becoming mentally ill. He accused us of being in the business of making iron lungs to treat people after they became hopelessly ill rather than being in the business of protecting people from illness in the first place. There are a number of versions of protective factors too, but as I remember it, the ones he shared with us was something like

### Examples of Protective Factors

- Having enough income to last the month and a little for emergencies
- Having stable housing
- Having a family (it didn't have to be an "intact" or "functional" family)
- Having some other adult who cared about them, for example a teacher, or coach, or relative, or minister, as an "adult protective shield"
- Having some roles outside of mental problems (some idea of who they are and what they want to be when they grow up)
- Spirituality / God

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This is another list that strikes a chord with me even though all of my work is with adults.

Whereas I used to spend a lot of time up front with clients focused on crisis management and prevention of hospitalization, more recently I've found that if we help them build these protective factors that the number and severity of their crisis goes down on its own.

Our Welcoming Team spends a lot of time helping people get benefits, especially writing comprehensive disability evaluations for social security. We practice "housing first"; loaning or sometimes even giving people money for housing and accessing housing subsidy programs. We help people reconnect with long lost family members. Sometimes we become the "adult protective shield" ourselves and sometimes we help them connect with other people. Many people say they need someone to call in an emergency and someone who will believe in them and not let them give up. We spend a lot of time in court rooms telling lawyers and judges that we'll try to help people meet their responsibilities if they'll give them another chance in the community. Our Village culture emphasizes relating to people in roles beyond their illnesses from the very beginning. We share ourselves with them, socialize and play sports, eat together, and give them jobs helping to run the Village. We actively encourage connections to local religious institutions and their personal spiritual practices.

I've come to believe that we do a lot of crisis interventions, including hospitalizations, because people don't have sufficient protective factors. That's like trying to put out a fire with a leaky bucket. What if our service plans had a section for building protective factors?

### Self Efficacy

I spent a full day this year with the LA county Jail staff; the jail that has repeatedly been called the largest mental hospital in the country. When I asked them to tell me how they thought their inmate-clients would describe themselves and their lives, they answered that they didn't think most of them could describe themselves. They saw themselves as drifting through life, not having any impact on what happened, trapped in unfair, unintelligible lives. They didn't have an identity or life of their own creation. They perceived everything as coming from outside themselves: Soothing, calming, and feeling good comes from cigarettes, drugs, alcohol, and sometimes meds. Money isn't earned. It's given to them. Punishments aren't consequences of their actions. They're the result of people "out to get them." This reactive stance makes it almost impossible to productively engage with mental health services to rebuild their lives.

There is a spectrum from those inmates all the way to people who are self confident, self responsible, goal pursuing, and recovering. We can overtly help people build inner strengths and move along that continuum. That's one of the main reasons it is so important for us to be empowering, collaborative, building shared decision making, client-driven instead of taking control of their lives. It's often better for someone to experience that

their decisions actually have consequences, good and bad, than to have a good decision made for them.

### Useful models for building self efficacy and self responsibility:

- Increasing one's ability to affect their own inner states directly – self soothing, comforting, emotional regulation, etc – instead of relying on others
- Increasing one's role in their own life – impacting their outcomes, fighting helplessness, avoiding victimization, taking responsibility, finding personal power, decreasing blaming
- Developing specific goal driven skills to achieve personal growth – illness and symptom management, housing, employment, social, emotional, etc.
- Making developmental progress through life's stages – e.g. Erikson's stages
- Building interpersonal and community based efficacy – interdependence skills, helping others, becoming a valuable neighbor and citizen, investing in others and the community, creating social networks and mutual support systems
- Increasing one's spirituality – moving from blaming and vengeance to acceptance and forgiveness, connecting to a "higher power", developing meaning and purpose in life

It seems to me that as people build their self efficacy in any of these ways that they are building the strength to overcome their illnesses and succeed in life. Different people will feel more connected with different approaches and they will be at different points in their development. We can help them find a model for building personal strength that works for them and begin the work wherever they're at.

### Building resilience by finding strengths in struggles

This is the kind of strength building I have experienced most powerfully in my own work. The endpoint of a successful recovery isn't "I'm so glad I met you. You really understand me. You gave me the right medications. You took care of everything. I know I can always rely on you to solve any problem for me. I'm going to stay in treatment with you and count on you forever because I'll never be well enough to handle things on my own" even though it often seems like that's our most common "positive outcome". The endpoint of a successful recovery is "I wouldn't have wished this illness on my worst enemy. The pain and suffering have been enormous, but in a strange way it has been a blessing in disguise. I've found and developed strengths I never knew I had. I've learned what's really important in life. There have been deep gifts from my deepest wounds. It's made me into the person I am today." To get to that endpoint, we must change our initial response from, "You did the right thing coming to see me. I'm a good

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doctor. I'm going to be able to help you" to "I can already see in you the strengths you are going to use to overcome this terrible illness." The hope in recovery is that they will develop, not that we will cure them.

Strengths aren't people's skills or talents or things we like about them. They are the things they will use to overcome their illnesses. Strengths can be internal qualities like determination, hopefulness, self awareness, self responsibility, pride, a strong work ethic, family values, and spiritual faith and strengths can be external resources like money, family, community, stable and safe housing, mentors and friends. Strengths can be discovered (or rediscovered) or newly developed. When someone has enough strength to overcome the next symptom increase, drug relapse, relationship breakup, job loss, family disappointment, or even tragic loss without falling apart entirely, without becoming homeless or jailed or hospitalized, without losing everything they've worked so hard for, then they have resilience. Our goal is not to protect them from tragedies but to help them build enough resilience to handle tragedies when they come, because they always will come.

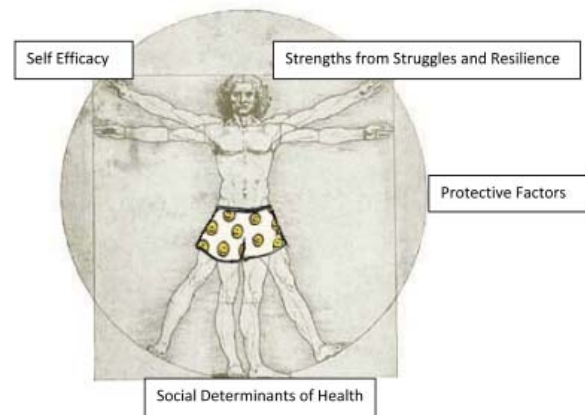
### Putting it all together

I was hoping that these four paradigms would fit together into some coherent model or journey (like the MORS) but if they do, I don't see it yet. On the other hand, I think that each of these four paradigms is valuable in its own right and worth

considering with each person I meet, so I don't want to subsume some of them under the others either. I settled on a visual image to include all four paradigms – Leonardo Da Vinci's man:

- Social determinants of health are the foundation, the ground he stands on
- Protective factors form the circle around him
- One arm rises with progressive self efficacy
- The other arm rises with strengths from struggles and building resilience

Together they form the strength to overcome mental illnesses.



## ABOUT THE AACP

The American Association of Community Psychiatrists (AACP) was formed in October 1984. The impetus came from a group of community psychiatrists who began sharing interests and concerns at the May 1984 American Psychiatric Association Meeting and at many local psychiatric meetings. We found that community psychiatrists are a concerned, dedicated, energetic, and underrepresented group. Our concerns had not been adequately addressed in other professional organizations, which often had other priorities.

The AACP has the following purposes:

- Promote and maintain excellence in the care of patients through the organization of psychiatrists practicing community mental health on state, regional, and national levels
- Help clarify and solve mutual problems commonly encountered by psychiatrists in community settings
- Inform and educate the public about the role of the community health system in the care of the mentally ill
- Establish liaisons with related professional organizations to advocate for relevant public policy issues
- Promote cooperation between psychiatrists and other professional, paraprofessional and consumer groups involved in mental health care
- Encourage training and research in psychiatry which will increase the number of committed psychiatrists in community settings

## Welcome New Members

### Area 1

Chris Gordon  
Marisa Derman  
Jennifer Greenwold

### Area 2

Sasha Rai

### Area 3

Robert Davis  
Holly Valerio  
Meredith Johnston  
Michael Nias

### Area 4

Jaina Amin

### Area 5

Barbara D'Orio  
Ellyn Johnson  
Barbara Brown  
Lilian Wong  
Timothy Coltrin

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# The role of Community Health Workers or Promotoras in the Integration of Mental Health and Primary Care: The answer to the missing link?



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According to Healthy People 2020, it is expected that people suffering from any mental or behavioral health condition, will have improved access to health care. This objective is to be obtained by improving early identification, referral and treatment of these individuals throughout the different clinics across the United States. The report emphasizes the need for prompt identification and treatment in underserved communities. By adequately integrating mental health services into community clinics it is expected that people will feel more comfortable discussing their mood, anxiety and other psychiatric and behavioral health conditions with health providers. This will not only reduce the ongoing stigma associated with psychiatric disorders but also will provide the basis for the integration of behavioral health into the new medical-home model (1). The void continues to exist in the availability of health providers that could meet the growing demands of mental health services in community clinics.

The literature has reported that access to mental health services remains an ongoing and intractable problem in rural communities, mainly due to the shortages of providers, services and poor outreach to the community (1, 2). As a result of these shortages, primary care providers and allied health professionals play a substantial role in the delivery of mental health services in rural communities. Since 1978, the lack of mental services among residents living in rural communities has been a major public health concern (1, 3). With almost 3,800 outpatient centers across the United States, Rural and Community Health Clinics continue to be the main source of primary care and mental health services in underserved areas (1, 4). Studies have reported that the prevalence of depression in primary care clinics is close to 50%; among those, close to 80% remain untreated due to lack of services and available personnel. These data does not take into account other untreated mood, anxiety and psychotic spectrum disorders. Patients with these conditions usually rely on their community clinics for the treatment of their initial symptoms (5).

Community health workers or *promotoras* or *promotores* are defined as trusted lay workers that provide a wide variety of health related services to individuals living in traditional underserved communities in order to improve prevention of disabling conditions as well as improve communication with the health care providers (6, 7). *Promotoras* are integral part of their communities. Their origin in the United States stems from the lack of access to health care, cultural and social barriers that

individuals from Hispanic or Latino origin were facing while living along the US-Mexico Border and dealing with chronic medical conditions. It is a model of delivering health care that has been widely used for many years in Latin-America in order to reach out to rural and indigenous communities where access to health centers and basic immunization services is difficult due to geographic location and isolation from main stream urban civilization.

The use of *promotoras* has been studied as a model to improve access to care, deliver basic services and prevent further decompensation of symptoms. This model has been very successful in the treatment and prevention of metabolic disorders and cardiovascular diseases (7). Recently, this model has been studied as a valuable tool for health professionals working in rural clinics to improve education, awareness, treatment and prevention of mental disorders, especially depression (7, 8).

With the ongoing changes that our profession will be facing in the near future, it seems that actively incorporating community health workers in the medical home model will be crucial to not only ease the transition of integration of psychiatry and primary care, but also to deliver basic psychosocial interventions that could mean the difference between relapse, hospitalization or serious decompensation of psychiatric symptoms among individuals living in different rural and urban communities.

Our role as community psychiatrists will be crucial in providing the expertise for educating, raising awareness and creating programs that will evaluate the importance of having *promotoras* as a crucial members of the medical team in order to close the gap between biological, social and psychological interventions that are needed to improve the delivering medical care to our patients living in our diverse environments.

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## IPS Announcements

This year's 63rd annual APA Institute on Psychiatric Services (IPS) will be held at the Marriot Marquis Hotel in San Francisco, CA from October 27th -30th. The theme is "Comprehensive and Coordinated Care: Bringing it all back home."

For those of you attending please note the following AACP activities taking place at the Marriot Marquis Hotel, San Francisco, CA:

### AACP Board Meetings

Day1 Wednesday, October 27  
12 noon - 7:30 p.m.  
Club Room, 2nd floor, Marriott Marquis

Day 2 Thursday, October 28th  
8 a.m. - 12noon  
Club Room, 2nd Floor, Marriott Marquis

### AACP Membership Forum

Date: Friday, October 28th Time: 4:00 to 6pm  
Location: Yerba Buena Salons 3/4, Lower Level B2, Marriot Marquis

### AACP Membership Reception

This year we are excited to hold the AACP Membership reception in the studio gallery of the Community Arts Program. The community arts program is a facet of the Central City Hospitality House, a community based organization that has served the homeless community in San Francisco's Tenderloin district since 1967. The Community Arts Program has supported and promoted thousands of artists by providing a studio workshop and gallery space where materials and space are offered free of charge. We invite you to enjoy the artwork while socializing with your colleagues.

Date: Friday, October 28th Time: 6:30pm to 8:00pm  
Location: Community Arts Program of the Central City Hospitality House  
1009 Market St, San Francisco, CA 94103  
Located at the Luggage Store Gallery  
(within walking distance of the Marriot Marquis Hotel)

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# Motivational interviewing as a Foundation for “Recovery-Oriented Care”

Michael Flaum, M.D.

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While the term “recovery” has been central in the addictions world for more than half a century, it is only within the last decade or two that people have been using this term with respect to mental illness. I first started hearing the term about a decade ago, and I spent quite a while struggling to figure out what it meant. I read many good articles, talked at length to several of the authors that I thought were doing the best work in the area, and attended numerous conferences and talks about recovery in mental health. After a few years I started to get the idea and I agreed with the underlying principles. I began including recovery-oriented language in my presentations, and I found that it resonated with many audiences. Interestingly, it seemed that my psychiatric colleagues were among the last group of mental health professionals to embrace the “recovery” construct. It wasn’t that they were opposed to the ideas as much as confused about what it was they could do to become more recovery oriented. Everybody nodded in agreement when I would go through SAMSHA’s “Ten Fundamental Components of Recovery”<sup>1</sup>, but they were left wondering “What is it that you are asking me to do?” I struggled with these questions myself, and I was certainly at a loss for helping anyone else.

Then, about 5 years ago, a colleague handed me Miller and Rollnick’s “Motivational Interviewing”<sup>2</sup>(the bible of “MI”) and said “read this and then let’s talk about recovery.” At the time, I had what I thought was a basic understanding of MI. It seemed to be a good, evidence-based psychotherapeutic method for addiction professionals. As that wasn’t me, I hadn’t spent much time going further. By the time I was twenty or thirty pages into the text however, I fully understood why she had given it to me, and her message.

It was clear that the spirit of motivational interviewing maps on very nicely to the principles of recovery. And most importantly, for those of us who shy away from terms like “spirit”, here was an understandable, tractable, teachable, and even ratable set of

skills that with some practice can and will enhance one’s capacity to deliver (or perhaps participate in) care in a recovery-oriented manner. You don’t have to wrestle with the concepts of what recovery in mental health means; if you are in the MI spirit, you are more than half way there. Add the technique, and you are fully there.

We have since built a curriculum for our junior psychiatry residents on MI. We want to get to them early in their training. I no longer talk to them about being recovery-oriented. I just expose them to this approach and this set of skills and by doing so, I am convinced that we are enhancing their capacity to deliver recovery-oriented mental health care. MI is not a panacea – and is not appropriate for all situations, but I can tell you that in my thirty-plus year career in psychiatry, nothing has changed my practice, the way I approach and talk with patients on a day to day basis than learning and practicing MI. I’m also a lot less burnt out at the end of a clinical day. And I no longer struggle with what it means to be recovery-oriented.

There are lots of good resources on the web to get you started<sup>3</sup>, and the MI community has done a very nice job with dissemination. Check it out.

## References/recommended readings and websites:

- <sup>1</sup> SAMSHA Consensus Statement on the Fundamentals of Recovery: [http://www.samhsa.gov/SAMHSA\\_News/VolumeXIV\\_2/text\\_only/article4txt.htm](http://www.samhsa.gov/SAMHSA_News/VolumeXIV_2/text_only/article4txt.htm)
- <sup>2</sup> Miller, WR and S Rollnick: Motivational Interviewing: Preparing People for Change. 2<sup>nd</sup> Edition. Guilford Press, New York, 2002
- <sup>3</sup> Motivational Interviewing <http://www.motivationalinterview.org/>

## AACP Calendar

**Nov 7-10, 2011** 24th Annual U.S. Psychiatric and Mental Health Congress Meeting Las Vegas, NV

**Dec 8-11, 2011** 22<sup>nd</sup> Annual Meeting American Academy of Addiction Psychiatry Scottsdale, AZ

**Feb 8-11, 2012** World Psychiatric Association Thematic Conference. Grenada, Spain

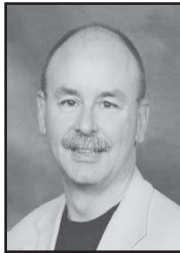
**May 5-9, 2012** 165th Annual Meeting of the American Psychiatric Association Philadelphia, PA.

**May 9 -11, 2012** Society for the Study of Psychiatry & Culture Annual Meeting “Globalization and the Dilemmas of Multiculturalism” New York, NY

### IDDT. From Dartmouth to Case Western to North Dakota.

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Integrated Dual Disorder Treatment (IDDT) is an evidence-based practice for those experiencing both serious mental illness and addiction. It began at Dartmouth Medical School Departments of Psychiatry and Community and Family Medicine, and has been fostered by Case Western Reserve University.



The North Dakota Department of Human Services' Southeast Human Service Center (SEHSC) is the largest regional human service center in North Dakota. Its largest city is Fargo, population 105,000. Despite assumed population homogeneity, the fastest growing minority population in the state is Native American (U.S. Census Bureau). Due to sponsored immigration, the metro region has one of the largest per capita immigrant resettlement programs in the country, with over 40 dialects spoken. (Metro Interpreter Resource Center). SEHSC has a close relationship with a Federally Qualified Health Center, the Family Healthcare Center.

Consulting with the Ohio SAMI CCOE (Coordinating Center of Excellence), the North Dakota Department of Human Services and Southeast Human Service Center implemented IDDT in 2007.

Modalities used include Motivational Interviewing, CBT, DBT and others, in both individual and group settings. Along with clients, team members include supervising clinicians, case managers, licensed addiction counselors, mental health therapists, case aids, RNs and psychiatrists. Support staff play a key role in welcoming clients to the program. Housing and employment specialists also take part in staffings.

IDDT is considered an evidence-based practice because research shows that individuals who receive it experience better recovery from both their illnesses: they have fewer hospitalizations and relapses, fewer criminal justice problems and more housing stability. Please refer to the following link: <http://www.ohiosamiccoe.cwru.edu/>

Outcomes from data compiled over the first four years of

implementation included: 29% decrease in emergency room admissions from the first year to the fourth year, 90% drop in acute psychiatric hospitalization days from first year to the fourth year, 70% drop in long term psychiatric hospitalization days from the first year to the fourth year, 98% decrease in number of days incarcerated.

Southeast Human Service Center received the 2010 IDDT Champion award from the Ohio SAMI-CCOE earlier this year; “With deep gratitude for your unwavering commitment to the implementation of evidence based practices and to improving access to and quality of care for people with co-occurring severe mental and substance use disorders in communities throughout the State of North Dakota.”

A key component of IDDT is person-centered care. Consumers note positive changes in working with the IDDT teams-

“I have been at SEHSC since 2001 and the IDDT team truly listens to my concerns. I have more say in my treatment and treatment options.”

“The best I have ever done in my recovery from mental illness and drinking is this past year while working with the IDDT team. Having my mental health therapist, my addiction counselor, case managers, nurse and case aide all working together with me an all being on the same page has been great!”

While the implementation of IDDT has been successful, there is continued effort to meet the individual needs of consumers/clients/patients in a person-centered and compassionate manner. Supported by the Department of Human Services, other regional human service centers in North Dakota are beginning the implementation process to include the evidence based practice of IDDT in their menu of services.

<http://www.nd.gov/dhs/locations/regionalhsc/southeast/index.html>

Andy McLean, MD, MPH  
Medical Director, North Dakota Department of Human Services

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## "Current Community and Public Psychiatry Fellowships."

### Alabama

#### **Univ of Alabama School of Med, Tuscaloosa Campus, Public Psychiatry Fellowship**

Director: Marisa A. Giggie, MD, MPAff, E-mail address: [maggie@cchs.ua.edu](mailto:maggie@cchs.ua.edu)

### California

#### **San Diego County Community Psychiatry Fellowship: San Diego, CA**

Interim Director: Marshall Lewis, MD E-mail address: [marshall.lewis@sdcountry.ca.gov](mailto:marshall.lewis@sdcountry.ca.gov)

#### **UCSF/SFGH Public Psychiatry Fellowship, San Francisco, CA**

Director: Christina Mangurian, MD E-mail address: [christina.mangurian@ucsf.edu](mailto:christina.mangurian@ucsf.edu)

### Connecticut

#### **Yale Fellowship in Public Psychiatry: New Haven, CT**

Director: Jeanne Steiner, DO E-mail address: [Jeanne.steiner@yale.edu](mailto:Jeanne.steiner@yale.edu)

Website: [www.medicine.yale.edu/psychiatry/education/clinfell/public.aspx](http://www.medicine.yale.edu/psychiatry/education/clinfell/public.aspx)

### Florida

#### **University of Florida Fellowship in Public Psychiatry: Orlando, FL**

Directors: Richard Christensen, MD and Wayne Creelman, MD E-mail address: [creelman@ufl.edu](mailto:creelman@ufl.edu); [rchris@ufl.edu](mailto:rchris@ufl.edu)

### Georgia

#### **Emory University Fellowship in Community Psychiatry / Public Health: Atlanta GA**

Director: Raymond J. Kotwicki, MD, MPH E-mail address: [rkotwic@emory.edu](mailto:rkotwic@emory.edu)

Website: [www.psychiatry.emory.edu/Community\\_Psychiatry.cfm](http://www.psychiatry.emory.edu/Community_Psychiatry.cfm)

### New York

#### **Columbia University Public Psychiatry Fellowship: New York, NY**

Director: Jules Ranz, MD E-mail address: [jmr1@columbia.edu](mailto:jmr1@columbia.edu)

Website: [ppf.hs.columbia.edu](http://ppf.hs.columbia.edu)

#### **NYU/Bellevue Public Psychiatry Fellowship: New York, NY**

Director: Manuel Trujillo, MD E-mail address: [jmr1@columbia.edu](mailto:jmr1@columbia.edu)

### North Carolina

#### **Durham VA Medical Center Interprofessional Fellowship on Psychosocial Rehabilitation and Recovery Oriented Services: Durham, NC**

Director: Dan Bradford, MD, MPH E-mail address: [daniel.bradford@duke.edu](mailto:daniel.bradford@duke.edu)

#### **UNC - Chapel Hill Department of Psychiatry and Center for Excellence in Community Psychiatry Fellowship in Community Psychiatry: Chapel Hill, NC**

Director: Brian Sheitman, MD E-mail address: [Brian\\_Sheitman@med.unc.edu](mailto:Brian_Sheitman@med.unc.edu)

### Ohio

#### **Case Western Reserve University, Public and Community Psychiatry Fellowship; Cleveland, OH**

Director: Patrick Runnels, MD E-mail address: [patrick.runnels@uhhospitals.org](mailto:patrick.runnels@uhhospitals.org)

### Pennsylvania

#### **Erie Community Psychiatry Fellowship: Erie, PA**

Director: Penny Chapman E-mail address: [pennydailey@gmail.com](mailto:pennydailey@gmail.com)

#### **University of Pennsylvania Fellowship in Public Psychiatry; Center of Excellence and Innovation in Public Psychiatry: Philadelphia, PA**

Directors: Trevor Hadley PhD and Larry Real MD E-mail address: [thadley@mail.med.upenn.edu](mailto:thadley@mail.med.upenn.edu); [larry.real@hhinc.org](mailto:larry.real@hhinc.org)

#### **Western Psychiatric Institute and Clinic Center for Public Service Psychiatry Fellowship Program: Pittsburgh, PA**

Director: Wesley Sowers, MD E-mail address: [sowerswe@upmc.edu](mailto:sowerswe@upmc.edu)

Website: [www.wpic.pitt.edu/education/CPSP](http://www.wpic.pitt.edu/education/CPSP)

### Texas

#### **UTSW/Metrocare Public and Community Psychiatry Fellowship Program: Dallas, TX**

Director: Osman Ali, MD E-mail address: [osman.ali@utsw.edu](mailto:osman.ali@utsw.edu)

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For more information:

Contact David Pollack, MD at [dapptsmt@gmail.com](mailto:dapptsmt@gmail.com) or go to AACP’s website  
<http://www.communitypsychiatry.org/aacp/cppms.aspx>



# 2011 MEMBERSHIP RENEWAL AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS

**Please Note:** The information requested on this sheet will be used to provide information for the Membership Directory. Please take a moment to fill in the form as you would like your listing to appear. Then return the form with your check to the address below. Dues include subscription to the *Community Mental Health Journal* and AACCP's newsletter *Community Psychiatrist*.

We now offer joint memberships with the American Association of Orthopsychiatry, American Association of Psychiatric Administrators, and American Association for Emergency Psychiatry. Take advantage of the many resources of these organizations along with those of the AACCP for a reduced joint membership fee!

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*Please list your name, title, address, and phone number(s) as you would like them to appear in the Membership Directory*

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Special Interest: Child/Adol. \_\_\_\_\_ Geriatric \_\_\_\_\_ Other \_\_\_\_\_

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