

American Association of Community Psychiatrists'
**Guidelines for Developing and Evaluating Public and
Community Psychiatry Training Fellowships**

May, 2008

Introduction:

Development of the psychiatric workforce has become a critical issue in most parts of our country, and the shortage of well-trained psychiatrists is most egregious in publicly funded settings. A number of factors have contributed to the difficulties in attracting talented young psychiatrists to settings that are in greatest need.

Over the past several decades, a great deal has been learned about the brain, pharmacology and biological processes contributing to behavioral health disorders and these aspects of treatment have enjoyed great emphasis in the training of future psychiatrists. At the same time, a worldwide movement embracing a recovery paradigm has developed and has been critical in empowering individuals to see themselves as persons of potential as opposed to being hopelessly mentally ill. Most psychiatric training experiences do not formally teach the values of a recovery orientation in working with individuals with a variety of behavioral health issues.

A variety of contemporary forces have converged to limit the scope of psychiatric practice, largely constricting its range to medication management and focusing on the biologic contributions to the expression of an illness. Training programs have often reflected this shift in the conceptualization of psychiatry, spending less time on promoting leadership, prevention, health maintenance, and psychosocial interventions than in the past. It is essential that opportunities are created to help our profession redefine itself and to ensure an engaged psychiatric workforce, committed to high quality services and treatment.

Purpose:

The purpose of this document is to create a framework for the training of psychiatrists that incorporates the elements needed to re-establish psychiatry's strong position in leadership and collaboration. To realize this vision, psychiatrists must develop a thorough understanding of recovery as a goal and a process and embrace the added value of effective partnerships with consumers, families, other disciplines, and stakeholders in addition to their expertise in managing medication and the biologic aspects of illness. At the same time, systems of care must creatively develop methods to support psychiatrists in this effort.

Critical to the training will be a greater understanding of what underlies the health and mental health of people and communities. Many of our country's neighborhoods are

socially and economically distressed with limited resources to promote mental health or treat mental illness. A public health perspective, incorporating skills in epidemiology, community-oriented scholarship, leadership, and advocacy, is a fundamental element of what community psychiatric practice needs to encompass today.

These guidelines offer an outline of the skills and knowledge that psychiatrists must achieve to practice effectively in the public sector from clinical, administrative and advocacy perspectives. In addition, it provides recommendations for methods that may be used, for both existing and developing programs, to achieve the identified competencies in graduating trainees. Although they are developed primarily for specialized training in public psychiatric practice, they should be useful guides for developing tracks for medical students, residents and for continuing medical education as well.

Competencies:

The didactic, clinical, administrative, and scholarship experiences will enable fellows to demonstrate:

Knowledge of:

- Prevention and public health approaches to community mental health
- Historical foundations of community mental health
- Effective leadership practices and consultation methods
- Administration and financing of public psychiatric services
- Integrated care (mental health, substance use, physical health and developmental disabilities) for co-occurring disorders
- Program development in public behavioral health systems
- Engagement practices and recovery focused care
- Approaches to maintaining healthy communities
- Services for special populations: Homeless, Criminal Offenders, Gay/Lesbian/Bisexual/Transgender, Addicted, Child and Family, Rural, Geriatric, Institutionalized.
- Disaster response and the effect of trauma
- Professional ethics and advocacy
- Evaluation methods and system analysis

Person - Centered Care: Assessment and Treatment

In addition to skills expected of graduates of general psychiatry training programs, fellows will be able to:

- Assess readiness for and commitment to change
- Determine areas of need in treatment planning process
- Develop collaborative, individualized treatment plans that are appropriate to phase in change processes.
- Incorporate non-pharmacologic interventions into clinical practice

- Assist people in self management and recovery activities
- Provide group and family treatments and understand their indications
- Approach assessment with expectation of co-occurring disorders. and address substance use, developmental and physical health problems commonly encountered appropriately.
- Employ motivational techniques and provide welcoming context for care
- Provide trauma informed, culturally sensitive care, including provision of alternatives to coercive treatments
- Incorporate spiritual context for care as needed.

Interpersonal and Communication Skills:

- Development of partnerships and “real” (versus transferential) relationships with clients
- Display cultural awareness and sensitivity
- Employment of engagement strategies in a variety of circumstances
- Assess non-verbal communication of self and others
- Use of language and concepts that are easily understood by stakeholders
- Relate easily in multi-disciplinary environments and facilitation of the treatment team process
- Employ facilitation and consultation methods appropriately

Professionalism:

- Understanding of the nuances specific to the varied populations and settings served in public psychiatry
- Respect, compassion, integrity, and honesty
- Sensitivity and responsiveness to a patients’ diversity of gender, age, culture, race, religion, disabilities, and sexual orientation
- Adjust role behavior according to circumstances

System-Based Care:

- Apply quality improvement principles and processes as a primary approach to identification and resolution of problems within systems
- Use documentation to facilitate achievement of clinical objectives
- Implement practices and guidelines informed by available evidence
- Integrate elements of care from all participants in the system of care
- Provide conduit for communication between elements of the system of care
- Apply principles of advocacy to facilitate systems change
- Effectively assess and navigate system policies and politics
- Mediation of disputes in administrative and clinical contexts and develop collaborative processes with disparate parties
- Function as team members as well as team leaders in community-based treatment settings including primary care clinics, community behavioral health centers and as consultants in interagency service collaboration.

- Assess medico-legal responsibility in collaboration with community agencies and use consultation appropriately.

Problem Based Learning and Improvement:

- Incorporate multiple inputs into problem solving activities
- Recognize and integrate principles for creating collaborative relationships.
- Incorporate effective methods for providing supervision, mentoring and teaching
- Recognize and maximize potential opportunities to provide leadership
- Use personal and professional networks to solve problems more effectively
- Identify processes that facilitate investment of interested parties in potential solutions to targeted problems.
- Demonstrate skill in developing partnerships in clinical interactions.
- Apply risk and benefit analysis in service delivery that maximizes the highest level of strength-based function in all aspects of consumers' lives.

Recommended Approaches for Achieving Competencies in a Public Psychiatry Fellowship

The competencies described above represent a broad range of knowledge and skills that would be desirable in trainees at the completion of a fellowship program. It is clearly an ambitious agenda, especially since most post-graduate training programs will be only one year. In this context, it will be essential that the training experience uses its time wisely and that it assures that the experiences and opportunities provided are relevant and clearly directed toward accomplishing the training objectives.

The following recommendations are formulated with this in mind. Many of the elements are drawn heavily from the experience of the Public Psychiatry Fellowship of Columbia University, which is the oldest and most experienced program in the country. Now operating for over 25 years, it has a well-established track record for developing psychiatrists who continue to work in the public sector, most often in leadership positions. While there are conceivably a variety of ways to accomplish the training objectives outlined above, incorporation of many of the elements of the Columbia program was not a matter of debate. However, these Guidelines recognize that flexibility and innovation are important qualities to preserve for developing new programs, and so are formulated in a way that allows the use of tried and true methods as well as the opportunity to test new ideas and areas of focus.

The recommendations are organized around some core activities that all programs should include in their curriculum. Beyond these core activities, some optional or focused activities are also identified. Core Activities are indicated by an asterisk.

Element I:* Academic or Didactic Curriculum.

Element II:* Primary Field Placement
Element III:* Faculty Supervision and Mentoring
Element IV:* Teaching, Presenting, and Supervising
Element V:* Research/Quality Improvement Project
Element VI: Systems Management Skills
Element VII: Community, Consumer, or Family Advocacy
Element VIII: Recovery/Resiliency Oriented Services
Element IX: Cultural Disparities, Competency and Sensitivity

I. Academic or Didactic Curriculum

The classroom experience should be a significant part of any Public-Community Psychiatry Training Program PCPTP. Many of the topics that will be covered in the program will be ones that fellows have had little formal exposure to in their general psychiatry training. A broad array of topics should be offered in the fellowship and should include the following:

- History of Modern Public Psychiatry
- Structure of Contemporary Public Psychiatry
- Funding of Public Human Services: Federal, State, Local
- Administration and Fiscal Management of Behavioral Health Services
- Regulation and Accreditation of Public Sector Programs
- Comprehensive Elements of Systems Design
- The Role of the Psychiatrist in Community Based Services
- Recovery Focused Care and Psychosocial Rehabilitation
- Practical Program Analysis and Evaluation
- Special Populations and Cultural Factors Impacting Clinical Practices
- Homelessness and Housing Policy
- Providing Leadership and Facilitating Collaboration
- Principles of Public Behavioral Health
- Interface of Primary Care and Behavioral Health
- Transformation in the Structure of Public Behavioral Health
- Community Based Research and Scholarship
- Public Mental Health Advocacy

The priority and emphasis given to the above topics may vary from program to program, and some programs may include additional modules to those listed. Each of the topic areas may include two or more sessions, each session lasting from 60-90 minutes. Ninety minute sessions have worked well in the Columbia program, which covers its curriculum in about 300 hours in the classroom over the course of the fellowship's duration. It is recommended that programs plan for this level of intensity.

The format for these classroom experiences can and should vary considerably. It is recommended that adult learning principles be incorporated into any curriculum however, and that there should be heavy emphasis on participatory learning processes, and problem based formats in which all participants (Fellow and Faculty) have opportunities to be both student and teacher. The Columbia Program has a Practicum in Mental Health Administration for example, in which fellows report on issues in their service placement which may be used to illustrate aspects of administration and systems dynamics as well as approaches to problem solving. Experiences of this type have been very well received and highly beneficial. Exposure to a variety of “experts” in the field and on particular topics adds diversity and enriches the didactic curriculum, and this is also recommended.

Faculty participation will also vary somewhat depending on the number of fellows in the program and the number of faculty that are regular or “core” members of the training program. A “core” faculty person would be expected to dedicate a significant amount of his or her time to this program (5+ hours/week), and several faculty members of this type provide continuity and coherence to the teaching program. Regardless of the size of the program, it is recommended that at least two core faculty members attend each classroom/seminar session. For smaller programs, this allows for a richer and more diverse discussion, for larger programs such as Columbia’s, it assures that the voice of experience is heard, with some diversity of perception.

II. Primary Field Placement

A primary placement in a community based behavioral health service agency throughout the year will provide a comprehensive and integrated clinical and management experience. It should allow fellows to assume an actual leadership role in these agencies in both clinical and administrative capacities and will allow fellows to become familiar with the dynamics, culture and politics of the system within which they are working. It is recommended that this placement be given 20 hours or more of the fellows’ scheduled time throughout the year.

Programs should contract with agencies that have demonstrated a willingness to enable Fellows to assume leadership roles and have indicated their commitment to providing positive experiences to Fellows. As programs mature, actual experiences working in these agencies can be used to determine future affiliations. Fellows should be allowed to select their primary placement site based upon their individual interests and the opportunities offered or characteristics of the agencies available. A broad array of general and specialty agencies as options should be available. A general guideline of 75% clinical and 25% administrative time should be followed by participating agencies.

Agencies will generally be expected to provide significant salary support for fellows, even in programs that have significant subsidies for the fellows’ salary. The specifics of that support should be negotiated and contracted with the agencies in advance of the Fellows’ selection of primary sites. This support can generally be recouped by billing for services, but even when this is not completely accomplished; it represents an investment

in these individuals that facilitates longer term commitments from Fellows to remain at their agency at the end of the Fellowship year. The Columbia program has demonstrated that this is the case for more than 50% of graduating Fellows in their program.

Some programs may choose to emphasize continuity and focus on one agency for all clinical and administrative field experience. This is the approach that the Columbia Program has used quite successfully. Other programs may wish to provide greater diversity of experience by adding some elective time to the primary placement activities. Electives might be either clinical or administrative. Whichever approach is taken, the rationale for providing an ongoing intensive experience is strong and should not be dismissed.

The size of the program should not impact the implementation of this element significantly. An alternate strategy is to create the fellowship around junior faculty positions. Participating agencies affiliated with the academic center could hire the Fellow full-time with protected class time and supervision time over the duration of the fellowship (usually one or two years). While this approach places some limits on the elective time that may be offered within the curriculum, it may be an attractive recruiting strategy for public behavioral health agencies. See “Infrastructure Development” section for specific examples of funding models.

III. Faculty Supervision and Mentoring

Core Faculty Preceptors: Fellows should meet weekly with one of the core faculty assigned or selected by them as preceptors. The preceptor role will be to provide primary consultation to the Fellow regarding the Fellow’s field placement experience and to discuss various problems or issues that arise within it. The Preceptor will also advise on the preparation of internal and external presentations and discussions, as well as teaching and supervisory activities. This type of relationship will facilitate the integration of the didactic curriculum and the field placement experiences. To assure that this happens, the core faculty should attend all of his or her assigned Fellow’s presentations, as well as much of the academic curriculum.

Field Placement Supervisor: In addition to the Core Faculty Preceptor, each Fellow should have an identified Field Placement Supervisor with whom s/he meets regularly for clinical and administrative supervision related to the primary placement site. In the Columbia Program, in many cases this Field Supervisor is a former Fellow who has remained in practice at a primary placement site. This kind of continuity is ideal in that it enables the Supervisor to provide insights from multiple perspectives and to empathize with the fellow’s experience. The faculty Preceptor should have opportunities to confer with the Fellow’s Field Placement Supervisor, and periodically, both may want to meet with the fellow concurrently. While it may often be preferable for a psychiatrist to fill this role, in many cases a non-psychiatrist will be a more practical and useful choice.

Mentoring: It is important to recognize that public sector community psychiatric practice can be lonely and isolative if not properly tended. Public and Community Psychiatry training programs should have the capacity to provide ongoing support and consultation, as well as academic activities and collegiality throughout training *and after*. Whenever possible, a Faculty mentor should be assigned in the person of someone outside the Core Faculty. This mentor does not necessarily need to be local or faculty affiliated. The AACP is one important resource for identifying and assigning mentors. The mentor may have a role in helping fellows expand their networks, create connections to professional organizations and activities, provide alternative perspectives on clinical and administrative problems, and in some cases to advocate for the fellow.

The program itself, through core and voluntary faculty can provide supportive resources for fellows as they move on to post graduate experiences. The Columbia program encourages graduates to continue an affiliation with the training program as supervisors and speakers. In addition, contact with alumni is maintained through consultations with them at crucial career junctions, at periodic alumni reunions, through a web site and an active list serve. These types of interactions reduce the isolation and under-stimulation that many new recruits to remote community practices might experience.

Consumer/Family Member Advisors: One of the important aspects of practicing recovery focused care is to have a thorough understanding of the recovery process and to be able to relate easily to a diverse array of people who are attempting recovery or who might be encouraged to begin this process. Although professional relationships and personal experience may provide some clues about how to effectively do this, the advice and support of a person in recovery and/or family members of persons in services can provide valuable insights and direction that might not be discovered otherwise. Providing a consumer and/or family member advisor is a good way to model development of mutually beneficial relationships and emphasize the value of the expertise gained by experience within the system and the use of resources beyond psychiatry.

IV. Teaching, Presenting and Supervising

Fellows must be provided opportunities to establish or hone teaching and supervisory skills that are essential to providing leadership in any system in which they may eventually work. Problem based or participatory learning formats within the didactic curriculum should provide many opportunities of this kind, with fellows taking the lead in researching and leading discussions on several of the scheduled topics. In the Columbia program one such opportunity is created around seven presentations the fellows are asked to give related to their primary field placement and their progress in it over the course of the year.

Additional opportunities should be developed for fellows to interact with and teach psychiatric residents, medical students, allied behavioral health professionals, case managers, and lay human services workers (i.e. police, correctional staff, educators,

social welfare agencies, consumer and family groups, etc.). These opportunities may be developed either within the primary placement site, or outside it.

In primary placement sites and in some cases elective sites, fellows can be called upon to provide clinical supervision or case consultations. Mentoring activities with medical students and other one to one relationship building in a professional context will be valuable experiences.

Fellows should also be encouraged to submit proposals to present their work or areas of interest at professional meetings that they may be attending. Fellows should be encouraged especially to be involved with meetings such as the Institute of Psychiatric Services and the Annual Meetings of the National Council for Community Behavioral Health Care (NCCBHC) and the National Alliance on Mental Illness (NAMI). Guidance on the preparation of proposals as well as the presentation itself should be a function of the faculty.

V. Research/Quality Improvement Project

Programs should provide fellows with an opportunity to develop and lead the implementation of a research or quality improvement project. In most cases, this will be most practical when organized around the primary placement site. Projects that provide useful, relevant information or improvements related to the provision of services will be most beneficial. Opportunities of this type will provide valuable experience in leadership and in overcoming obstacles to achieving desired outcomes. Projects should provide opportunities for the practical application of principles considered in the didactic section of the fellowship.

The project should be identified early and continued throughout the year. There should be an expectation that it be a project that can be completed prior to the completion of the fellowship so that some evaluation and analysis can be presented prior to graduation. In many cases, a separate project supervisor will be desirable, in others the Core Faculty Preceptor or the Field Placement Supervisor will provide appropriate guidance.

VI. Larger Systems Management

Some fellows or programs may want to emphasize participation in larger systems administering behavioral health care. While the skills developed in the primary placement site should serve fellows well in various parts of the systems with which they become engaged, first hand knowledge of the working of those larger systems and how they move will be valuable, particularly for those interested in creating systems' change.

Fellows may be provided opportunities to develop electives that incorporate governmental and financial entities charged with administering behavioral health systems of care. Depending on their interests, fellows might select from a range of activities conducted by such entities, i.e. quality management, outcome measurement, financial

planning, service planning, accreditation and credentialing, consumer and family relations, systems transformation, etc. Participation might take the form of membership in existing or forming committees and/or workgroups or consultation to administrative processes. When possible, preceptor within the entity will provide guidance and information to the fellow to assist his or her participation.

VII. Community, Consumer, or Family Advocacy

Programs or individual fellows may wish to develop a public health focus by enhancing organizational skills useful in advocating for change or empowerment of various stakeholder groups. Electives may be developed around consultative activities with regional or national groups such as NAMI, Mental Health America, Federation of Families or other consumer advocacy groups. Community organizations interested in improving the resiliency of their neighborhoods might also be interested in consultation for planning and implementation of strategies for change. Grassroots efforts to create systems' change may provide additional opportunities for fellows to develop an understanding of how systems change, and the elements that must coalesce for this to occur.

Experiences of this type will underscore and create an understanding of the importance of developing partnerships and collaborative relationships with communities, consumers and their family members to create plans in which all parties are invested. These types of activities may be particularly attractive to fellows who begin their training with well developed leadership skills and who are looking for experiences in which they can advance or enhance them. In many cases, a separate preceptor or supervisor will be helpful to the fellow selecting these activities.

VIII. Recovery/Resiliency Oriented Services

As consumers become more and more invested in directing their own care and making choices about the services they receive, and as transformation efforts gain momentum at the federal, state, and local levels, it will be important that fellows have a thorough understanding of recovery and resiliency principles and how services can be delivered in a manner that supports them. Community psychiatrists have a long tradition of delivering services in collaboration with consumers and in promoting autonomy and choice. These views and practices have not generally permeated the systems in which they work however.

Programs, or individual fellows within a program, may wish to emphasize this aspect of public and community practice to better equip them to facilitate transformation efforts in the communities in which they may eventually practice. Opportunities for fellows to work in systems that are beginning a transformation process, or that have made significant progress in that process should be available to fellows as either a primary placement or an elective experience. This type of experience will provide a practical

application of materials considered in the in the didactic aspect of the fellowship. This may also provide a concentration for the fellow's project in a particular aspect of recovery oriented practice such as, collaborative service planning, service development, housing, medication management, etc. A special supervisor who has used services and is in recovery may be assigned to provide guidance in thinking about how service providers, and psychiatrists in particular, may contribute to recovery/resiliency development processes.

IX. Cultural Disparities, Competency and Sensitivity

The impact of culture on mental health is well established, in terms of how mental illness is perceived, diagnosed and treated. There are clear differences in the risk and protective factors associated with mental illness and chemical misuse,(or substance use) as well as access to services, between various communities (or ethnic minorities) and the general population. These disparities are often associated with certain demographic or socio-economic variables.

A program, or a fellow within a program, may wish to focus on obtaining competence in the treatment of a particular cultural group, developing sensitivity to relevant issues and addressing them in clinical practice, or in transforming systems of care in a manner that reduces the obstacles to receiving competent care that members of many groups encounter. Opportunities may be developed for fellows to select a primary placement or an elective that is multi-cultural or that specializes in the treatment of a particular cultural group. They also may develop a project or work with administrative entities that are addressing cultural issues. These experiences will also enhance material considered in the didactic aspect of the fellowship.

Principles for Infrastructure Development

Academic Relationship: The underlying structure and support for a specialized training program must be carefully considered to provide a reasonable expectation for success. A relationship with an academic institution would be difficult to dispense with, yet, if that institution is not committed to the success of the program it will be difficult to sustain. This commitment must be more than direct financial investment, and must assure that the core faculty has a reasonable amount of protected time and administrative assistance. In most cases this is correlated with a department's overall vision for the role of community psychiatry within the department. A critical aspect of generating interest in trainees is the value placed on community psychiatry in general psychiatric training and the level of respect shown to faculty members associated with these programs by the departments within which they operate. Recruitment will be aided greatly when candidates perceive that their activities will be valued and supported by the department they would be joining.

Financial Support: Funding for the program will also be a critical element in establishing stability, and this must often come from sources outside the affiliated

academic institution. The expense of faculty time and administration cannot easily be sustained indefinitely regardless of the level of commitment of the institution. Public-Academic partnerships, such as that developed between Columbia University and New York State have been successful models for stable funding. The state must be persuaded that their investment will yield an enhanced capacity to recruit psychiatrists to the public sector within the state. Columbia's experience provides useful evidence that this can, in fact, be accomplished. Programs must be creative in thinking about alternative sources of support for faculty salaries if inadequate public sources are available. Foundations may be able to provide assistance in some cases.

Depending on the level of independent funding available to the training program, fellows will need to generate enough income to cover all or part of their salaries. Since these are non-accredited programs, program directives will have relative flexibility in arranging clinical placements that can bill directly for services provided by the fellow. They must be vigilant as well, to assure that fellows' time is not exploited and the agencies respect guidelines for inclusion of fellows in an array of clinical and administrative activities. When stable arrangements are in place to support the compensation of fellows. There is further flexibility to expand the number of trainees the program takes on.

Funding Models: Some specific examples of funding mechanisms have been identified by the Columbia University Public Psychiatry Fellowship over the years and are described below.

(1) Fellows are paid completely by the training institution on training lines. This allows for maximum flexibility in designing the Fellows' field placement experiences but limits the number of Fellows who can be hired to the number of training items available to the training program.

(2) Fellows are paid partially by the training institution on training lines and partially by the field placement agency. The two payments together are roughly equal to the training line. This limits a Fellow's placement options to those agencies that can afford to provide some of the funding to a Fellow, but allows an increase in the number of Fellows who can be recruited on a fixed number of training items. Because the field placement agency pays the Fellow at a rate less than that of a staff psychiatrist, the Fellow does not have to generate as much revenue through clinical services, and the agency can apportion some time for management experience.

(3) Fellows are hired by the field placement agency on a 0.6 FTE basis and paid at the higher rate of a staff psychiatrist. The training institution supplements this salary to account for the time spent in classes. This variant provides less flexibility in the field placement experience, because the field placement agency is paying the Fellow at a staff psychiatrist rate and consequently demands more clinical service.

(4) Fellows are paid by the field placement agency as a full-time staff psychiatrist, with the Fellow released for one day a week of class time and paid for that time by the field placement agency. This variant provides the least flexibility of the field placement experience, because the field placement agency expects the level of service normally

provided by a full-time psychiatrist. Some Columbia Public Psychiatry Fellows prefer this variant, because they receive a higher salary than they would if they were paid on a training line.

Under versions 2, 3 and 4, Fellows receive varying salaries, depending on the expectations and resources of the field placement agency chosen by each Fellow. The agencies that pay more generally expect a higher number of hours on site or a higher percentage of time devoted to direct clinical service. Since these programs are non-accredited, it is not a problem to pay Fellows different salaries.

Agencies can use the varying funding mechanisms to increase the incentive for the Fellow to remain at the field placement agency at the end of the fellowship year. Version 4 provides the strongest incentive for a Fellow to remain at the agency because s/he is already a junior faculty member during the fellowship year. In version 3 the Fellow is a part-time junior faculty member, providing a somewhat lesser incentive to remain at the agency. Since in version 2 the Fellow is partially paid by the field placement agency while in version 1 the Fellow receives no funds from the agency, version 2 is an easier transition to a junior faculty member at the end of the Fellowship year,

Community Networks: Another aspect of infrastructure development is creating relationships with programs and agencies in the community to provide clinical and administrative experiences for the fellow. The more choices that are available to meet the particular needs of a fellow, the broader the appeal will be to a diverse array of potential candidates. One aspect of creating this array of choices is that there could frequently be programs that are available but not chosen. Having some strategies to keep these “dormant” agencies active will need to be attended to. Providing opportunities for psychiatrists working in those agencies to be involved in the academic program, even though they may not be working with a trainee directly, is one such strategy. The provision of ongoing technical assistance is another possibility.

Alternative Methods for Achieving Competencies and Early Career Development

While these guidelines focus primarily on the training of post-graduate fellows, we recognize that there are other methods that allow psychiatrists to develop competency in providing services in the public sector and other community settings. The competencies section will provide guidance for the development of alternative pathways regardless of the structure selected. Many of the strategies outlined in the Methods section will also be applicable, but will need to be modified according to the needs and limitations of the circumstances within which trainees and trainers are working.

One alternative approach would be the development of a track within a general psychiatry training program which incorporates exposure to community settings with

clinical and classroom work that address the training issues outlined above. This approach might be particularly appealing to programs that have the ability or necessity of providing most clinical rotations in publically funded sites. Some capacity to incorporate longitudinal experience with leadership opportunities would of course be optimal. Additional opportunities to obtain mentoring and exposure to career development activities following graduation would also assist these early career psychiatrists to develop competency in community-based practice.

Many psychiatrists who are early in their careers are working in public settings or are considering doing so, but frequently feel that they do not have all the skills necessary to do so effectively. Programs might be developed to provide supervision and mentoring to them as they are engaged in full time community practice, as well as opportunities to participate in relevant didactic activities. Didactic content could be provided in a variety of ways, including Internet, literature review, teleconferencing, and concentrated face-to-face classroom work. Programs of this type might extend over the course of two to three years, since they will be less concentrated than a fellowship experience. As with fellowships, funding for these activities will be critical, and once again, public-academic partnerships may be the optimal model. In some cases, agencies may be willing to invest in the development of such “early career” fellows as a way to enhance their ability to recruit and retain high quality psychiatrists. Centers providing specialized training in community psychiatry may be well suited to provide a base for these programs. Projects may also be developed through professional organizations. The AACP and NCCBHC are examples of this approach, using government and/or private funding to support their faculties.

Still other alternatives may be considered, but the models described here will be the most common approaches to training the public psychiatry workforce and establishing a more clearly defined identity for those engaged in community psychiatric practice.

Conclusion

The challenges of providing competent care for diverse populations who have had limited access to behavioral health services in the past, and who come from diverse demographic backgrounds, are growing. There has been widespread recognition that our systems of care need to change to better serve evolving population needs and that our profession needs to change in order to meet the needs of those transforming systems of care. Advanced training opportunities in public and community psychiatry will enhance and expedite our profession’s capacity to meet developing needs of the psychiatric workforce. This document creates a vision for the development of these training opportunities. It should be useful to those developing training programs to ensure a comprehensive training experience. At the same time, it will be useful to potential trainees in their evaluation of programs offering training, and will provide guidance to them in their selection of a program that best suits their needs and interests.

REFERENCES

AACP: Keystones for Collaboration and Leadership: Issues and Recommendations for the Transformation of Community Psychiatry. 2007 www.communitypsychiatry.org

Goetz R, Cutler DL, Pollack D, et al. A Three-Decade Perspective on Community and Public Psychiatry Training in Oregon, *Psychiatric Services* 49:9: 1208, September, 1998

Ranz JM, Deakins SM, LeMelle SM, Rosenheck SD, Kellermann SL: Core Elements of a Public Psychiatry Fellowship, *Psychiatric Services* (Manuscript Accepted for Publication) 2008