



CPA Position Paper

Filling Gaps in Psychiatric Education: Skills in Administrative Psychiatry and Knowledge of Mental Health Systems, Services, and Policy

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Introduction

In Canada, the education of psychiatrists has focused primarily on the development of expert clinical skills with attention, albeit to a lesser degree, to components of biological and social sciences directly relevant to clinical practice. Knowledge and skill acquisition have been directed toward the production of clinical experts in the treatment of individuals, families, or small groups of individuals, with little attention to system-wide approaches to mental health care or to psychiatric services that address the needs of larger populations. Psychiatrists often find that their training has not equipped them adequately to navigate through the complex organizations that govern and manage health care services. Consequently, psychiatrists may remain excluded from decisions regarding policy directions and changes in the delivery of mental health services.

In general, psychiatric educators have not prepared psychiatrists with knowledge about the governance, organization, or operation of the health care systems within which psychiatric services are provided (1).

In recent years, Canadian psychiatrists have become less likely to undertake practices that operate in isolation from other components of health care services. Increasingly, psychiatrists work in active collaboration with their colleagues in various shared care arrangements, often within programs that employ an interdisciplinary mix of health professionals, such as those found in hospitals and community mental health programs (2). The directors of these interdisciplinary programs often ask psychiatrists to participate in leadership and decision-making tasks because of the unique expertise acquired in psychiatric specialty training and qualifications. However, such involvement

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commonly requires the application of administrative skills and knowledge of mental health systems, and these are rarely provided within the curricula of psychiatric training programs.

In the past, the development of skills in administrative psychiatry was often considered an area of subspecialty interest that might be pursued by a small coterie of psychiatric trainees who were anticipating particular administrative roles later in their careers, for example, as program directors or hospital department heads (3–6). In some programs, psychiatry residents could elect to attend brief courses delivered externally to postgraduate training programs, which provided basic training in management principles and often addressed practical skills such as team building and conflict resolution. Similarly, a few trainees developed administrative skills through opportunities available within medical associations, such as those provided through resident associations. Perhaps most often, such knowledge and skills were developed by psychiatrists on their own initiative after they had completed their formal training and certification in psychiatry.

In view of the extensive changes to the structure of Canadian health care systems in recent years (7), it has become evident that it is no longer feasible to depend solely on a few psychiatrists who identify a special interest in administrative careers to maintain an active role for psychiatrists in the operation and planning of Canadian mental health services. Most psychiatrists will need to be knowledgeable about the delivery of mental health services and will also require basic administrative skills if members of the psychiatric profession are to exercise their roles in Canada's health care system fully, maintaining an active contribution to the planning, development, and delivery of mental health services.

In addition to the need for wide dissemination of administrative skills and knowledge of mental health systems among members of the psychiatric profession, there will continue to be a need to prepare a smaller group of psychiatrists to take up specialized roles with particular expertise in administration and advanced knowledge of mental health systems and policy. Thus, effective methods are needed to identify and support psychiatric trainees and practising psychiatrists who demonstrate a particular interest in or capacity for administrative careers.

In this position paper, we discuss how recent changes in Canadian health care systems have created the need for psychiatrists to possess administrative skills and knowledge of mental health systems, services, and policies. We describe gaps in psychiatric education that exist currently as a consequence of these additional demands, provide recommendations to address these gaps, and promote a response by educational programs to the shifting needs of Canadian psychiatric practice.

Current Context and Demands for Learning

Most psychiatric trainees have limited exposure to the administrative executives, chief officers, government decision makers, and agency directors who govern and manage mental health services. During their clinical training in hospitals and mental health sites, psychiatry residents will likely have contact with psychiatry department heads and clinic directors but may develop only a cursory knowledge of their roles, responsibilities, and activities. Generally, no organized opportunities are in place for residents to develop an understanding of key system components, such as health authorities, government ministries, legislative assemblies, advocacy organizations, professional colleges and associations, and other bodies involved in mental health system administration and policy development. Psychiatrists first encounter many elements of these systems only after they have begun practice and without training in administrative skills or knowledge of the organization and operation of mental health services. Consequently, psychiatrists often find themselves in a disadvantageous position during such early encounters.

In the course of their residency training or early in their practices, psychiatrists first experience system-related issues when a problem is encountered (for example, when a resident is unable to access an essential service for a patient, or a psychiatrist disputes a decision by administrators to reduce a program's resource allocation). Typically, such introductions to the system are frustrating ones, particularly when the psychiatrist is stymied by the complex organizational structures and mechanisms that are involved in operations, planning, and decision making.

Such unsatisfactory first encounters may set the tone for long-standing difficulties in relationships among psychiatrists as well as other members of the mental health system. In particular (and in solidarity with physician colleagues in other specialties), psychiatrists will frequently assume an antagonistic position in their relationships with government staff and decision makers. This pervasive antipathy toward government decision makers is probably in part owing to Canadian procedures for physician fee negotiation that pit provincial governments and physician associations against each other in repeated contract disputes and arbitration. These disputes typically involve fierce confrontation and create resentment that tends to colour all interactions between the 2 groups. With this backdrop, psychiatrists require sophisticated administrative skills to overcome antagonism and mistrust and to engage government staff in collaborative initiatives to improve mental health services.

Canada's health care system has undergone profound restructuring to decentralize the governance and authority

of health care delivery. Health care services in most provinces are now administered by several regional health authorities, each with a mandate to fund and operate health care resources for a population residing within specific geographical boundaries (8). This shift was driven by a policy that anticipated that a better quality of health care would be established in each region of the country if the resources and funds were controlled locally. With the establishment of new health regions and the arrival of a new cadre of executive officers and decision makers, extensive revision and redesign of the health care system is occurring widely. Therefore, possibilities exist to promote advancements in psychiatric services and to obtain additional resources as a function of such system redesign. However, the current shifts might create the opposite result instead, that is, reallocations that remove psychiatric resources and diminish the quality of mental health services. Knowledgeable and skillful intervention will be required by representatives of the psychiatric profession to influence the new group of decision makers and ensure that system redesign includes constructive plans to advance mental health services.

With the windows of opportunity for change wide open, other groups are also seeking to influence decision makers and advance their own perspectives. To a greater extent than do other medical specialists, psychiatrists compete with a large group of professional and semiprofessional groups who claim the ability to provide better services at a lower cost and seek to replace psychiatrists in various roles through a reallocation of public health care funds. The network of practitioners and agencies that shares these interests includes counsellors, volunteer workers, nurse practitioners, occupational therapists, consumer advocacy groups, criminal justice workers, psychologists, social workers, lay therapists, pharmacists, clergy, employee assistance programs, and others. With a new group of decision makers and an array of potentially competing service providers, psychiatrists will need skillful representatives participating in the planning processes that will shape the future of mental health care, including psychiatric practice.

Psychiatry appears to be unique among health service professions in having organized and active movements that call for its containment or eradication. Members of the "antipsychiatry" movement often explain their antagonistic position toward psychiatric practice as the result of past experiences of psychiatric treatment that were perceived to have been harmful or in contravention of their rights and freedoms. Since policy-makers are regularly lobbied to prohibit or curtail the provision of psychiatric services, the psychiatric profession requires knowledgeable representatives to ensure that decision makers receive and attend to evidence that demonstrates the value of psychiatric care.

Even within medical circles, psychiatry must often fend off attempts to confiscate the resources allocated for the provision of psychiatric services, such as budgeted funds, space allotments, hospital beds, and human resources. Among the various medical services and programs operating in hospitals and health centres, psychiatric and mental health services are traditionally assigned a low priority by other specialists, and it is common to encounter concerted efforts to remove psychiatric services or relocate them in some distant and undesirable setting. The relatively low prioritization of psychiatry within medicine may represent a process parallel to the widespread stigmatization and discrimination experienced by psychiatric patients (10).

Often, government decision makers, mental health advocacy groups, and the general public expect psychiatrists to take active roles in policy decisions, for example, in relation to legislation such as mental health acts or in determining whether psychiatric inpatient programs should be expanded or contracted. Within multidisciplinary clinical teams, it is often expected that psychiatrists will participate in leadership and (or) mentorship roles on the basis of the advanced training they receive in various aspects of mental health care.

When psychiatrists are armed with the necessary knowledge and skills required to participate in administrative activities and leadership, they are often found to be particularly capable. It is natural that many of the skills that psychiatrists gain in clinical practice (such as conflict resolution and advanced interpersonal communication, as well as their understanding of group dynamics, behavioural reinforcement principles, and other aspects of human behaviour) will enhance their ability to function as administrators and leaders. In many instances across Canada, psychiatrists who have undertaken key leadership positions have been highly respected and appreciated by patients and colleagues in various sectors.

In addition to the need to develop strong advocates and leaders among psychiatrists described above, there exist other compelling reasons to provide psychiatrists with knowledge about mental health systems and administrative psychiatry. One important reason is related to the patterns of practice psychiatrists choose to undertake. With a solid understanding of the mental health system and the population needs, psychiatrists may be more likely to set up their practices in a manner that contributes significantly to and complements the other services and supports operating in their communities. Although increasingly rare, there have been instances in which psychiatrists, when beginning new practices in communities that had anxiously awaited their arrival, encountered furor and disbelief when it was discovered that they had set up office psychiatry practices considered by their colleagues to be of little value in meeting the priority needs

of their communities. If they were armed with knowledge about population needs and the configuration of mental health services, psychiatrists might be more likely to design their practices to make more significant contributions and to work in harmony with colleagues delivering other components of care. Such issues regarding practice patterns are particularly germane to the delivery of psychiatric services in rural or underserved communities, but they are also relevant in urban centres where psychiatrist-to-patient ratios are relatively high.

With fuller knowledge of mental health systems and their operation, psychiatrists may be more able to assist their patients in accessing a wide range of clinical services and community supports that may be of significant benefit, for example, housing, financial assistance, disability benefits, work rehabilitation, legal representation, and supported education. In addition, psychiatrists may become more effective in supporting patients' advocacy efforts, such as those seeking to alter provincial or federal policies affecting people with mental illness.

The need to increase the Canadian research capacity that addresses mental health systems and services has been identified (9). There would be benefit in producing additional psychiatrist-researchers who might contribute to the creation of new knowledge to improve mental health systems. If they receive exposure to pertinent issues and potential research questions about mental health systems during their education, psychiatrists may be more likely to develop an interest in the area and pursue related research activity later in their careers.

For the various reasons listed above, psychiatric educators in various countries have concluded that psychiatric training must prepare them to be knowledgeable about the structure and operation of the mental health system and must provide basic administrative skills (11,12). There has also been acknowledgement of the need to ensure that adequate numbers of psychiatrists receive additional specialized training to prepare them for administrative leadership roles (3,6,13). In recognition of this need, psychiatric educators in several countries have instituted specialized courses and programs. One such program in the US includes a dedicated course in the core curriculum given during the third and fourth years of postgraduate psychiatry training (14), and the results of a survey of its trainees indicated that they considered the course to be a valuable component of their education. In several programs in the US and Australia, psychiatry residents have opportunities to participate in structured electives that provide specialized training in administrative psychiatry and may also elect to undertake fellowship training in administrative psychiatry following certification in psychiatry (11,12). The National Institute of Mental Health (NIMH) also supports structured fellowships in mental health services research at several US universities, which

are available to psychiatrists following residency training (15).

In Canada, efforts to enhance psychiatric education in this area are in the early stages; however, some promising initiatives can be identified. A new course, provided throughout the PGY1 year, has been introduced recently in the University of British Columbia Department of Psychiatry. One day each month, the residents are released from their other medical duties and gather to receive a series of psychiatry seminars. The course is designed to provide a comprehensive orientation to the mental health system and to provide an opportunity for residents to consider how the role of psychiatrist relates to the system at large. The seminars include exposure to government decision makers, mental health stakeholder groups, historical and political influences on psychiatric systems, and current issues challenging the profession. The course, which has been well received by the PGY1 trainees, is given at this early stage of their postgraduate education with the rationale that residents will be open-minded and free to give thoughtful consideration to the issues and questions raised. Possibly, residents may be less open to considering innovative approaches to psychiatric practice later in their training when they have been immersed in traditional practice settings and influenced by the extant practice patterns of their supervisors.

Another recent Canadian development is the initiation of a national training program in mental health services research funded by the Canadian Institutes of Health Research (CIHR) and offering doctoral and postdoctoral training opportunities in several universities across the country (16). This will provide opportunities for individuals to receive specialized training in mental health and addictions services and policy research, and it is hoped that psychiatrists will be among those who undertake this advanced training.

Some psychiatric residency training programs currently provide elective rotations in administrative psychiatry, and in some sites, residents may opt to attend brief courses in health care administration that may be offered to physician specialists or to a mix of health care professionals. In addition, many psychiatry residents have had opportunities to gain administrative skills and knowledge of mental health services, systems, and policy through activity in professional associations, particularly residency associations such as the Canadian Association of Interns and Residents (CAIR) and affiliated provincial associations. These associations provide specific courses and opportunities for residents to gain relevant knowledge and skills. Nevertheless, only a few psychiatric trainees currently undertake such opportunities.

Relationship to CanMEDS 2000

The Royal College of Physicians and Surgeons of Canada developed the Canadian Medical Education Directions for Specialists 2000 Project (CanMEDS 2000; 17), designed in part to assist postgraduate specialty training programs in responding to Canadian societal health care needs. The recommendations in the following section of this paper are closely allied with the fundamental objectives described in the CanMEDS 2000 report: 1) expanding the focus of specialty training from the interests and abilities of providers to greater inclusion of the needs of society and 2) orienting postgraduate training programs to consider the needs of individual patients in the context of the population at large.

The authors of CanMEDS 2000 recommend profound changes to the educational development and evaluation of medical residents in Canada; they seek to establish and articulate a diversity of roles among specialists, including those of communicator, collaborator, manager, and health advocate. Specialist curricula, including residencies, are being challenged to change, and the incorporation of the professional competencies proposed by CanMEDS 2000 must be carefully considered.

Recommendations

It is recommended that the elements of an expanded curriculum could best be introduced at different stages in the education of psychiatrists. Some material may be most appropriately introduced at the undergraduate level, such as exposure to the population health perspective alongside a didactic introduction to the composition and dynamics of health services systems. Postgraduate curricula should support opportunities to gain practical experience whereby residents gain first-hand experience with decision makers and researchers who are involved in health services research. The methods of applied research and the dynamics of communicating findings to policy makers entail hybrid skills that require practicums and mentorship to be taught to residents. In addition, opportunities for access to relevant continuing professional development will be important, as many psychiatrists become more aware of the importance of such knowledge and skills once they have taken up practice and encounter first-hand the opportunities and challenges inherent within mental health systems.

Recommended domains of learning include the following (11–14):

- familiarization with systems of health care administration and practice, including the role of political institutions and bureaucratic bodies in decision making and policy development
- attention to population health concepts, including social determinants of mental health and mental illness

- greater attention to the tools and techniques for critically appraising the application and implementation of mental health research findings
- development of skills in communicating mental health information and needs to other disciplines as well as to mental health managerial decision makers.

The following specific topics could be considered for inclusion (11,18):

- the organization of the health system with a focus on mental health services and supports
- inputs, outputs, and outcomes in mental health services and the mental health matrix model
- applying epidemiologic data to assist mental health service planning
- estimating and understanding cost implications of mental health services
- policies and practices associated with mental health reform
- models of mental health service delivery
- measuring the quality and performance of mental health systems
- communicating with mental health stakeholders
- current issues in mental health service delivery, for example, postdeinstitutionalization issues, private vs public health care services, and the impact of human rights legislation on service delivery
- principles of management of human resources, including skill development related to team building, conflict resolution, communications, and finance.

These recommended reforms call for significant modifications to the historic model of psychiatric training. To address these gaps in curricula, it may be necessary to provide opportunities for faculty to develop skills and to forge partnerships with decision makers where these are not currently in place.

Challenges and Limitations

It is recognized that the prospect of this educational reform faces several challenges. Some training opportunities, such as practicums with decision makers, may require financial support that is not currently in place to offset even such basic expenses as travel. It should also be noted that existing curricula are saturated. The desired coordination between undergraduate and residency programs compounds the challenges posed by these reforms. The recommended didactic instruction may need to be introduced into established courses, while advanced practicums may need to be offered as alternatives to existing training electives. Even so, limited numbers of teaching faculty members are available to promote these reforms within Canadian psychiatry departments. The network of collaborative relations between academic psychiatrists and policy makers is limited, and a strategy to augment faculty skills and contacts may be a prior necessity.

A further financial obstacle concerns the incentives for graduates to undertake novel applications of psychiatry in practice. Compensation for policy input is limited; for example, no fee-for-service tariffs exist for such activity. The realignment of financial incentives is fundamental to implementing the recommendations of CanMEDS 2000 to facilitate the introduction of numerous changes in practice. The recommended changes will potentially clash with ascending models of psychiatric training, including those that emphasize traditional medically oriented approaches. Finally, an unintended and undesired potential outcome of these recommendations may be the emergence of competition with other relatively underrepresented and important elements within the current psychiatry curriculums. Departmental committees should continue to review psychiatric training in its entirety, and the reforms recommended herein should be introduced alongside additional necessary curriculum changes to further enhance the professional training of psychiatrists.

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