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Overcoming Barriers to Increase the Contribution of Clinical Psychologists to Work With Persons With Severe Mental Illness

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Abstract

Psychosocial treatments for persons with severe mental illness (SMI) have been developing rapidly over the past decade. Despite the fact that people with SMI are often in the greatest need of care, clinical psychologists are not currently playing a major role in their treatment and are underrepresented compared to other disciplines in this area such as nursing, social work, and psychiatry. In this article, we present possible reasons for clinical psychologists' underrepresentation and discuss motivators, potential opportunities, and ways for clinical psychologists to take a greater role in the provision of services for persons with SMI. Implications for the training of clinical psychologists are discussed.

Keywords

clinical psychologists; services; severe mental illness

INTRODUCTION: THE UNDERREPRESENTATION OF CLINICAL PSYCHOLOGISTS IN WORK WITH PEOPLE WITH SEVERE MENTAL ILLNESS

Over the last decade, conceptual developments, research findings, policy changes, and the involvement of various stakeholders (including consumers and family members) have led to important advances in the understanding and delivery of services for people with severe mental illness (SMI). The goal of these services has shifted from "maintenance" to recovery (Anthony, 1993; Deegan, 1993) and community integration (Carling, 1992; Wong & Solomon, 2002), which promotes the goal of consumers living meaningful lives as integral members of their communities of choice, despite and beyond the limits of their psychiatric disorders. Value-laden guiding principles have been developed to promote these goals, including the promotion of basic civil rights, self-determination, informed and active involvement of consumers in decision making, and the provision of evidence-based practices (EBPs) delivered with high fidelity (Drake, Mueser, & Lynde, 2005). EBPs are interventions that research has shown to be effective in assisting consumers to achieve desirable outcomes (Mueser, Torrey, Lynde, Singer, & Drake, 2003) and facilitate both recovery and community integration (Bond, Salyers, Rollins, Rapp, & Zipp, 2004; Drake et al., 2001).

Over the years, clinical psychologists have made many important contributions to work with people with SMI. These include developing and conducting functional assessments; studying the reliability and validity of diagnostic categories; developing illness management and behavioral techniques to reduce stress and increase medication adherence, coping and educational programs; and developing, implementing, and evaluating EBP (many of these contributions are summarized in Smith et al., 1993). Despite these important achievements and the fact that several single psychologists have made major contributions to this emerging field (often referred to as psychiatric rehabilitation), most agree that only a small proportion of clinical psychologists choose and work with persons with SMI (Levant et al., 2001; Rollins & Bond, 2001). Supporting this view are national survey findings. The Substance Abuse and Mental Health Service Administration (SAMHSA) reported that in 2002 roughly 9% of psychologists in the United States were primarily employed by settings that are most likely to serve people with SMI, such as mental health clinics and mental health hospital settings (an additional 5% worked in a hospital or clinic as a secondary setting; Duffy et al., 2002). These figures represent a decrease from figures SAMHSA reported for 1999, when they found that 12% of psychologists were primarily employed in mental health hospital or clinic settings (West et al., 2000). The long-term trend that this reflects emerged also from a recent study (Norcross, Karpiak, & Santoro, 2005) that compared surveys of members of the American Psychological Association (APA) division of clinical psychology over the preceding 43 years (1960–2003). Results revealed that while in 1960 the primary work of almost half of clinical psychologists surveyed was in settings treating primarily people with SMI (mental and general hospitals and out-patient clinics), in 2003 the proportion had decreased to 19%. The small proportion of psychologists involved in working with people with SMI stands in sharp contrast to other disciplines; for example, roughly 30% of both social workers and psychiatrists reported working primarily in mental health hospital or clinic settings in the SAMHSA's surveys (Duffy et al., 2002).

Although there is little argument that clinical psychologists are underrepresented (relative to other disciplines and their own past record of representation) in working with people with SMI, the reasons for this underrepresentation have not been thoroughly explored. The unique contribution that psychologists can make to work with people with SMI also needs to be elaborated. Furthermore, there is a need for discussion of ways to change psychologists' conceptualization of their role in working with people with SMI in order to increase their involvement in this field. In this article, we consider reasons why clinical psychologists are underrepresented in the treatment of people with SMI, discuss the unique contributions that they can potentially make to this area, and suggest ways to increase the involvement of clinical psychologists working with people with SMI.

POSSIBLE REASONS FOR CLINICAL PSYCHOLOGISTS' UNDERREPRESENTATION IN WORKING WITH PEOPLE WITH SMI

Training Factors

Clinical psychology training programs, at least in the United States, are not usually geared toward preparing and encouraging students to pursue careers that involve working with people with SMI. Evidence from surveys of graduate programs and internship programs indicates that very few offer a subspecialty in psychiatric rehabilitation, provide updated courses relevant to working with people with SMI, or have faculty members who specialize in this area and can influence the training or curriculum (Hoge, Stayner, & Davidson, 2000; Johnson, 1992; Millet & Schwebel, 1994; Wohlford, 1994). At the time of Millet and Schwebel's 1991 survey of APA-accredited clinical psychology training programs, it was found that roughly half of the programs graduated no students with a specialty in the treatment of people with SMI in the previous five years. Program directors who participated in this survey complained about the

lack of faculty with specialization in this field and made comments like “few psychologists really want to work in this area.” As Wohlford (1994) noted, a substantial proportion of program directors even indicated that they would discourage students from pursuing a career in this area. Even without overt discouragement, it has been noted (Johnson, 1992) that most clinicians tend to serve clients for whom the methods with which they are familiar are appropriate, rather than adapting new practices needed to treat other populations. In addition, most graduate programs are located on college and university campuses as opposed to medical centers, which may further limit opportunities for exposure to medical settings and facilities that treat individuals with SMI.

Considering the impact of graduate school training, it is not surprising that clinical psychologists often feel incompetent to deal with some of the unique challenges of working with people with SMI (Hoge et al., 2000). Challenges may include client behaviors such as violating rules of interpersonal conduct, asking highly personal questions, and talking in a way that does not lend itself easily to a therapeutic dialogue. Psychology trainees may also feel overwhelmed by the degree of systemic knowledge (about the disability, health insurance, housing, and vocational rehabilitation systems) that they need to obtain in order to provide competent services for people with SMI. The need to coordinate with external forces may further contribute to feeling incompetent. Clinical psychologists might be accustomed to clients with more obvious “insight” and “motivation” (i.e., clients that refer themselves into treatment), and thus may not have an orientation that is conducive to using techniques such as assertive outreach, which are often necessary when working with people with SMI.

Coming to terms with these issues may require specialized supervision and training from psychologists with extensive expertise in the provision of recovery-oriented services and evidence-based practices (Hoge et al., 2000), although in practice this is often not the case. Instead, the discouraging messages clinical psychologists often receive may be partly reflective of the attitudes of professionals trained in an era before recovery was considered to be a possibility, as well as the stigmatizing attitudes that still persist among mental health professionals (e.g., Van Dorn et al., 2005, found that mental health professionals in a U.S. state did not differ from the general public in their desire for social distance from people with mental illness, or their beliefs that people with mental illness are likely to be violent). Without appropriate supervision that is grounded in a recovery orientation, psychiatric rehabilitation principles, and a thorough knowledge of EBP, psychology trainees may be unduly influenced by these stigmatizing attitudes and may become discouraged from future work with people with SMI.

Systemic Factors

Beyond the impact of training, the practical and concrete issue of reduced revenue in the public mental health sector impacts the involvement of psychologists in this area. Most consumers with SMI are served by the public mental health sector, whether through Veteran’s Administration services that are federally funded, or local/county community mental health centers that are primarily funded with Medicaid and state dollars. Following the failure of healthcare reform in the 1990s, Medicaid systems began to convert from fee-for-service models to managed care models for people with disabilities (Hagglund, Nack, & Frank, 1997). Simultaneously, community mental health services began to be increasingly “privatized” (i.e., contracted to not-for-profit agencies rather than provided directly by states or municipalities; Yanos, 2005). The end result of these forces has been that community mental health providers have become increasingly competitive and “bottom line” conscious. As Medicaid does not reimburse differently for psychotherapy services that are provided by clinical psychologists versus other professionals, it has become difficult for many administrators to justify having a (higher paid) clinical psychologist provide services in place of a master’s-level staff person.

Hour for hour, the agency may lose money by employing psychologists over master's-level staff to provide these direct services. In the current fiscal environment where Medicaid growth is being "reconciled" and the trend of flat growth or cuts is not likely to change, it may be difficult for clinical psychologists to position themselves as competitors in the public sector if their identity is simply that of "therapist" or "service provider."

POTENTIAL ROLES FOR CLINICAL PSYCHOLOGISTS WORKING WITH PEOPLE WITH SMI

Despite the somewhat discouraging picture we have presented above, we do believe that clinical psychologists are in a unique position to take a leadership role in developing, enhancing, and implementing services for people with SMI, and change the trend of psychology's increasing marginalization in this area. This optimism was recently reflected in a contemporary "President's Column" by the president of the APA (Levant, 2005), which argued that psychology is uniquely qualified to lead national initiatives embracing the recovery model reflected by the New Freedom Commission report and other sources (Department of Health and Human Services, 1999, 2003, 2005). A recent extensive survey (Kaslow et al., 2004) identified eight core competency domains possessed by all psychologists. These include (a) the scientific foundations of psychology and research, (b) ethical, legal, public policy/advocacy, and professional issues, (c) supervision, (d) psychological assessment, (e) individual and cultural diversity, (f) intervention, (g) consultation and interdisciplinary relationships, and (h) professional development. In addition to these skills, we further note that clinical psychologists are the most experienced of the mental health professionals in both interpreting and conducting research, given the requirements of their predominantly "Boulder-Model" training programs (O'Sullivan & Quevillon, 1992). Given this combination of competencies, we believe that clinical psychologists have a distinctive set of skills that can make a unique contribution to the services provided to people with SMI. Below, we discuss several distinct roles that clinical psychologists can take to significantly contribute to services for people with SMI.

Research–Practice Bridging

Currently, there is good evidence that, despite the availability of effective psychosocial interventions that have a positive effect on the outcomes of people with SMI, there is a large gap between the types of services that are offered in routine mental health settings, and the services recommended by the research literature (Drake et al., 2001; Torrey et al., 2001). In assessing reasons why EBPs are not routinely incorporated into treatment settings, Corrigan et al. (2001) highlighted the role of implementation barriers, which include resistance from line-staff and administrators due to a lack of understanding of research. Elsewhere, one of us (P.T.Y.) has discussed how "patient-oriented clinician-researchers" with active ties to clinical settings can help to communicate the importance of evidence in terms that staff and administrators understand and value, and, therefore, serve as "bridgers" between the research and practice worlds (Yanos & Ziedonis, 2006). Patient-oriented clinician-researchers may also be better aware of the challenges involved in implementing empirically validated treatments into settings where populations may be more diverse and resources more constrained, and better equipped to come up with strategies for dealing with these challenges.

Even if psychologists do not conduct research themselves, they are uniquely qualified to fulfill part of the patient-oriented clinician-researcher role by serving as intermediaries in translating interventions discussed in the research literature into clinical practice. Many routine mental health service settings are beginning to consider or planning to make changes as they become aware of the disjoint between the EBPs that are being recommended in the literature and the actual services they are providing. However, they may lack expertise to implement and adapt

treatment manuals in order to turn their desire (or a state-mandated directive) to change into a reality. Clinical psychologists' combination of solid clinical skills and understanding and appreciation for research can contribute to bridging the gap between research and practice in these service settings (see also Drabeck & Goldfried, 2000). Corrigan (1995) has made a similar argument, noting that psychologists' didactic and practicum training, which includes learning and behavioral theory, social and organizational psychology, as well as an emphasis on psychopathology and its assessment, provides unique skills that can prepare them for "champion" roles that can help to transform service settings to ones that provide quality services for people with SMI. Tasks associated with the bridging function may include adapting treatment manuals for local implementation, training and supervising staff (discussed in greater detail below) on the process of implementing the interventions, and overseeing the collection of outcomes data required for internal "performance monitoring" efforts.

While some clinical psychologists might not be interested in taking on the "bridging" role, several may be very excited by the potential that it offers to make a unique contribution. Many young psychologists often express perplexity that they are no longer able to make use of the research skills they acquired during doctoral training once they complete their dissertations and take clinical jobs in the field. Viewing themselves as potential "bridgers" who can serve as connectors between the research and practice worlds may provide an exciting opportunity and professional identity for new psychologists.

Direct Service Delivery

There are also several evidence-based techniques that clinical psychologists are particularly well trained to provide to people with SMI. Notable examples include cognitive-behavioral therapy for people with psychotic symptoms, medication adherence interventions, and the treatment of comorbidities, which will be briefly discussed below.

Cognitive-behavioral therapy for psychotic symptoms (Turkington, Kingdon, & Weiden, 2006) includes a broad set of approaches to improve adaptive and emotional functioning based on theories of learning and behavior change. These approaches are comprised of Socratic questioning, cognitive-behavioral assessment, functional analysis, goal setting, cognitive restructuring, relaxation training, and behavioral activation. Clinical psychologists, who typically receive good training in cognitive-behavioral treatments for anxiety and depression, tend to be well trained in these techniques, and applying them to the treatment of people with psychotic symptoms does not require the learning of many new skills. Psychologists are therefore well suited to provide this type of treatment with appropriate supervision.

Compliance therapy (Kemp, Hayward, Applewhaite, Everitt, & Anthony, 1996) is based on behavioral interventions that share the use of learning principles to help people with SMI use their medication effectively. Common strategies that have been used and found effective (Mueser et al., 2002) include a functional analysis (assessment of the cues and consequences of the adherence behavior) followed by the development of an individualized plan to change the cues and consequences associated with not using medication effectively. Typical elements of such plans include establishing cues for taking medications, developing medication routines, using a self-monitoring calendar, and reinforcements. Again, clinical psychologists tend to be well trained in such behavioral techniques and qualified to provide this type of treatment in routine settings.

Levant (2006) has suggested that clinical psychologists can take on the specialized clinical roles in working with people with SMI such as conducting diagnostic assessments to tease out complex comorbidities, and delivering empirically validated treatments for these comorbid conditions. We agree and emphasize that an example of one specific contribution that psychologists can make in this area is in assessing for the presence of very common comorbid

conditions such as posttraumatic stress disorder (PTSD) and social anxiety disorder (Kendler et al., 1996; Mueser et al., 1998). The presence of these comorbid conditions can seriously impact functioning and quality of life among people with SMI, but is typically missed in routine treatment settings (e.g., Mueser et al., 1998, noted in their study that the vast majority of people with SMI that they found to have comorbid PTSD did not have PTSD noted in their charts). Psychologists may be able to draw on their more general training backgrounds to serve as local “specialists” in diagnosing and treating these conditions, which may be less familiar to psychiatric rehabilitation providers who receive less training in the treatment of anxiety disorders. Addressing these conditions in the public sector is also wholly consistent with the emphasis on integrating EBPs into routine treatment settings, which we discussed above.

Consultation/Supervision

It has been argued elsewhere that, beyond being well equipped to provide quality services to persons with SMI (Smith et al., 1993), clinical psychologists may also be uniquely qualified to serve as consultants and supervisors of psychiatric rehabilitation services (Conning, 1991; Levant et al., 2001). Here, we extend this position and argue that clinical psychologists can act in a supervisory role in the crucial stages needed to have EBPs implemented with “fidelity” (Bond, Evans, Salyers, Williams, & Kim, 2000), and to have evidence-based treatments become a more enduring part of the treatment culture in routine practice settings (Drake et al., 2001). Because the level of education, training, and experience of practitioners in the field of psychiatric rehabilitation varies widely (with many services provided by bachelor-level staff), clinical psychologists can take a leadership role and serve as trainers, consultants, and supervisors that can help other staff acquire core clinical competencies needed to provide evidence-based and recovery-oriented services. Clinical psychologists with a solidly updated “toolkit” of clinical skills can help the staff acquire and appropriately use these skills to enhance the quality of their service delivery.

THE CHALLENGE FOR TRAINING PROGRAMS

Exciting New Psychologists About Working With People With SMI

Just because the possibility for the bridging, consulting/ supervisory, and “specialist” roles we discussed above exists does not mean that new clinical psychologists will take them. Psychology training programs will need to first take on the task of exciting new psychologists about the possibilities and importance of working with people with SMI. There are several obvious ways that training programs can help clinical psychology students to become motivated to work with persons with SMI, despite the fact that these students may not have envisioned such a career trajectory when they first decided to pursue graduate training. First, there is the reality that persons with SMI suffer from the most disabling symptoms of all the mental illnesses and are often in the greatest need of high-quality services (Levant, 2006). The moral imperative to assist those in the greatest need is quite pressing and students may be persuaded as they experience the significant assistance they can provide to these individuals.

Second, there is the potential to excite students about being involved in an important process of transforming the mental health system to one that delivers high-quality services to persons in need, which can make use of the “bridger” role discussed above. In order to promote the realistic possibility that clinical psychologists will be able to function in a “bridger” capacity, graduate training and internship programs will need to encourage new psychologists to more effectively “sell” their unique skills for translating and implementing EBPs to potential employers in the public sector. This may be required because many administrators (from the fields of psychiatry and social work, or from business backgrounds) may be unaware of the unique combination of solid behavioral techniques and understanding and appreciation for research that distinguish clinical psychologists from other mental health professionals. As they

become aware of these unique skills sets, administrators may be convinced that it is worth their while to invest resources in hiring clinical psychologists, in spite of the fiscal constraints that exist in the public sector.

Dealing with the sense of incompetence and other anxieties that students feel when they enter into treatment experiences with people with SMI can be counteracted by effective supervision. With appropriate supervision, many trainees can experience how rewarding working with people with SMI can be after they have overcome their initial concerns. Coming into contact with the great potential for growth and change that can be unleashed by effective psychosocial treatments can be a very exciting and formative experience for psychology trainees. A follow-up survey of the experiences of doctoral student trainees who worked with one of us (P.T.Y.) in a psychiatric rehabilitation setting supported this view. For example, one student indicated that, while he sought the experience primarily to improve his qualifications for internship, he found the work exciting and later took a job at a state hospital because of his positive experiences during his externship. Another student stated that he was initially unsure of the contribution that he could make to treatment of people with SMI, but felt empowered to work with this population once he gained experience in a setting where treatment was both structured and effective.

CONCLUSION

We conclude that there is reason for hope and even optimism about the potential for clinical psychologists to use their unique combination of skills to make a meaningful contribution to working with persons with SMI in the future. The involvement of clinical psychologists can contribute to the transformation of routine treatment for people with SMI to one in which the overarching goals of recovery and community integration are attained through the delivery of effective interventions implemented with high fidelity; outcome monitoring; and embedded values of choice, opportunity, and shared decision making. However, to make the increased involvement of clinical psychologists a reality, training programs will need to make a deliberate effort to alter the way that they presently train clinical psychology students, which currently discourages them, either indirectly or overtly, from considering the provision of services to people with SMI as a viable career option. Training programs will need to take on a new perspective that encourages students to see the exciting opportunities that exist for applying their unique research and clinical skills as well as to discuss the moral imperative to apply them to the treatment of those who are often most in need of high-quality care.

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