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Public Psychiatry's Accomplishments: Bound for Nowhere?

TO THE EDITOR: In a letter to the editor of *Psychiatric Services* (1), some members of the senior Yale Psychiatry faculty viewed the analyses I offer in "Perhaps I Touched the Minaret, or How Patient-Centered Care Remains a Dream" (2) as driven by "defeat," "despair," "discouragement," and "disillusionment" (1). Their only reference to the analyses was the "unfortunate" citing of 1960s programs as "evidence that public psychiatry has declined." I still take my later failures to replicate this 1960s collaboration with the Texas Department of Rehabilitation as such evidence (3). The state-sponsored training resulted in full-time, continuous competitive employment of multiple chronically hospitalized patients. In contrast, a recent benchmark for employment success was 41% working at least one day within a three-month period. I leave it to readers to decide whether competitive employment opportunities for people with severe mental illness have declined.

The Yale critics go on to cite "tremendous progress . . . in recent years" (1). One example they provide is "jail diversion" at Yale (1). In the years up to 1997, when I retired from academia, I worked in no community or department where we allowed people with a mental illness to be sent to jails. For example, the Springfield, Illinois, police routinely called our 24-hour on-call case manager or Community Support Network office. A typical request was, "We have someone who we think is your client, and if she isn't, she should be. Will you come?" We went to the site and took responsibility if the person was our client or mentally ill (4).

The Yale critics reported participation in the Connecticut jail diversion program. Has diversion met the needs of New Haven's citizens who have psychiatric illness? In 2015, Supervisory Assistant Public Defender Bevin Salmon, who works at the New Haven Superior Court, said "I've been doing this for about 13 years, and . . . to see [my] mentally ill clients incarcerated because there aren't enough treatment spots for them . . . has been a constant problem" (5).

The state of social and community psychiatry truly disappoints me (2), and reports from academia provide no reassurances. Contrary to the Yale critics' speculations, as I said in my Personal Accounts column (2), I remain gratified by my work and by the patients I have helped and who have taught me medicine. I have learned from them that we cannot depend on all patients' coming to our offices. Psychiatrists have pioneered prevention programs to identify vulnerable people with severe mental illness who are living in community settings and to provide active care over time to improve their well-being. Programmatic prevention can be used to reduce police encounters and the need for diversion. Two elements are important in this effort. First, interventions in the community can address functional impairments and disabilities of people with severe mental illness: homelessness, unemployment, substance abuse, encounters with police, and so forth. Second, collaborative arrangements can provide on-site mental health workers to intervene when police are concerned about a client or nonclient with mental illness.

By understanding our patients, we become experts in the tailoring of medicine and environments to protect and restore health to individuals. By having all medical students and psychiatric residents master the skills of preventive interventions, home visits, agency collaborations that concern a patient, and on-site home or work supervision to ensure that patients take their prescribed medications, we take an important step toward overcoming today's adversities.

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Relationship Between Supervisor Factors and Therapist Knowledge, Attitudes, and Use of EBP in a Large Public Behavioral Health System

TO THE EDITOR: Research has identified the importance of supervisors in implementation processes, given their ongoing support of therapists' skill development and competence in evidence-based practice (EBP) (1,2). It is therefore crucial to understand the specific supervisor characteristics that facilitate or hinder implementation of EBP. Findings from the organizational and management fields suggest that supervisor understanding of and commitment to innovation may affect staff knowledge of and attitudes toward EBP (3). Two supervisor characteristics that may reflect supervisor understanding of and commitment to innovation include supervisor knowledge of and attitudes toward EBP. Given the limited research in this area, we examined whether supervisor knowledge of and attitudes toward EBP are related to therapist implementation factors (knowledge of and attitudes toward EBP) and implementation outcomes (the self-reported use of EBP).

Quantitative survey data were collected from therapists (N=114) and their direct clinical supervisors (N=35) within 22 organizations who participated in at least one of four cognitive-behavioral therapy (CBT)–focused EBP implementation initiatives in Philadelphia. The selection of organizations for participation in the EBP initiatives has evolved from a nonuniform selection of organizations to a competitive process where organizations apply for participation through a request-for-applications process. Organizations and participating therapists were provided with gold-standard training and ongoing consultation with expert treatment developers (4); organizations implementing one of the EBPs were provided an enhanced financial rate for the provision of that EBP.

Participants were recruited from the aforementioned publicly funded community behavioral health organizations that were implementing EBP. Between January and June 2015, potential participants attended a one-time meeting where research staff presented an overview of the research study, obtained informed consent, and administered measures assessing supervisor and therapist knowledge of and attitudes toward EBP, therapist use of cognitive, behavioral, and family therapy modalities, and information about the supervisory context.

Using PROC MIXED in SAS 9.0, we conducted nine mixed-effects linear regression models to test the relationship between supervisor characteristics (knowledge and attitudes) and therapist implementation factors (knowledge and attitudes) and outcomes (CBT use). Random intercepts for organization were included to account for nesting of therapists within organizations.

Contrary to our expectations, supervisor knowledge of and attitudes toward EBP were not predictive of therapist knowledge, attitudes, or self-reported CBT use. This was surprising in that previous literature documents the relationship between supervision and successful implementation of EBP in community settings (5). One explanation for the null findings may be supervision content and delivery methods. Although supervisors reported that nearly all clinicians were receiving supervision, less than 15% (N=4) of supervisors reported using active learning methods (such as audio recording), which are evidence-based supervisory strategies (5). In addition, perhaps supervisors do not exert influence on individual therapists but rather inculcate an environment at the organizational level to facilitate innovation implementation (2). Further qualitative and quantitative research is needed to better understand the role of supervisors in facilitating EBP implementation in community settings.

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Quality of Inpatient Psychiatric Care and Consumers' Trust in the Mental Health Care System

TO THE EDITOR: The quality of inpatient psychiatric care remains underresearched, especially from the perspective of the consumer. To our knowledge, whether quality of episodic inpatient psychiatric care predicts consumers' trust in the mental health care system has not been assessed (1). In an exploratory survey-based study, we evaluated the association between consumer-rated quality of inpatient psychiatric care and trust in the mental health system, independent of factors such as diagnostic history and admission status (voluntary versus involuntary), hypothesizing that quality of inpatient care is positively associated with trust in the system.

Participants (N=52) were conveniently recruited from 15 states through social media, e-mail Listservs, and flyers. The mean±SD age was 44.22±13.1, 75% (N=39) were female, 60% (N=31) had a four-year college degree, 50% (N=26) had private insurance (50% public), 85% (N=44) were white, and 50% (N=26) were involuntarily admitted.

Participants responded to an online survey that used the Combined Assessment of Psychiatric Environments measure (2) to assess experienced quality of inpatient psychiatric care, trust (versus distrust) in the mental health care system, diagnostic history (versus no history) of psychotic features, admission status (voluntary versus involuntary), time since hospitalization (zero or one year, two to four years or five or more years), education (college versus no college), race (white or nonwhite), number of hospitalizations (one, two to four, five to ten, or more than ten), and type of insurance coverage at time of hospitalization (public, private, or no insurance). After running preliminary correlations and t tests, we used multiple logistic regression, with trust in the mental health system as the dependent variable and experienced quality of inpatient psychiatric care as the primary independent variable.