

Discussion Group # F1 Title: Providing Leadership

Identified Needs:

1. Clarification of the role of Psychiatrists in transformation
2. Clarification of the recovery model in clinical, economic and political arenas
3. Political voice for medical and psychiatry/unity
4. Development of leadership skills that support a recovery model
5. Recruit, train and include residents in leadership opportunities

Recommendations:

1. Develop a statement on the role of Psychiatrists in transformation
2. Define the recovery model for clinical, economic and political arenas. Develop advocacy strategies to support our goals as a professional
3. Develop AACCP as a resource for collaboration and leadership training for community psychiatrists and residents
4. Develop future leadership opportunities for those interested in community psychiatry thru AACCP
5. Explore ways for AACCP to provide education and information on leadership and networks of leadership for problem solving and coaching

Discussion Group # F2 Title: Training Psychiatrists

Identified Needs:

1. Learning to listen
2. Attending to health of trainee and of system
3. More time for doctors to spend with patients
4. Communication between team members
5. Trauma training
6. Full-time clinician educators

Recommendations:

1. Reward for good training
2. Rewards for flexible systems to work
3. Advocacy efforts by doctors, consumers, family and team
4. Increased funding to support flexible programs
5. Exposure to consumers world
6. Consistent treatment providers

Discussion Group # F3 Title: Professional Ethics

Identified Needs:

1. Concise set of general principles to guide ethical conduct
2. Principles to help guide individuals working in systems which may require unethical conduct
3. Recovery focused ethical principles
4. Ethical principles that recognizes the importance of social context
5. Ethical principles which recognizes community psychiatry as the bases of psychiatry

Recommendations:

1. AACP work group to develop and promulgate a concise set of principles reflecting all of the above (AACP)
2. Active and critical engagement with APA concerning ethics principles (AACP)

Discussion Group # F4 Title: Psychiatry and Rehabilitation

Identified Needs:

1. Definition of the psychiatric rehabilitation as restoration of function. The field has remained isolated, underused and not well appreciated.
2. Psychiatric rehabilitation should be consumer center and focused on the person served. The person served should determine the goals meaningful for them and psychiatric rehabilitation is a tool to achieve that.
3. Unclear role of the psychiatrist and other disciplines in psychiatric rehabilitation. Often psychiatrists do not understand their own role in psychiatric rehabilitation. They often view themselves as only involved in the medical treatment of the person served.
4. Significant need for training in the concept of psychiatric rehabilitation. There are multiple challenges including the fact it is not required in the residency program curriculum.
5. Our disability system limits chances of recovery and instills a fear of losing it if they work. This is a concern experienced by service users and their clinicians thus limiting the use of psychiatric rehabilitation.

Recommendations:

1. This field needs to reach out to others, improve mentoring and better funding to facilitate this.
2. Education and training of psychiatrists and psychiatric profession. They can be trained to ask the persons served "What do you want to achieve?" to determine the rehab goals.
3. Training psychiatrists in basic qualities of developing relationships, connection, trust and listening, as essential ingredients in working in the area of psychiatric rehabilitation.
4. Education focused on the role of various disciplines involved in psychiatric rehabilitation to support person served reach his goals.
5. Using seminars or working with persons in recovery and doing well as teaching techniques to improve the knowledge and change attitudes in psychiatrists during their residency training (pre-service).
6. Use in-service training to teach specific skills for psychiatrists to understand their role and others in the multidisciplinary team.
7. Government to use incentives more.
8. Learn from person served and peer support. Professionals to find solutions for this challenge and this should be a recommendation to the government.

Discussion Group # F5 Title: Collaboration in Medication Management

Identified Needs

1. Greater interface of physical health/behavioral health providers:
  - a. Inadequate physical/behavioral health collaboration
  - b. Greater attention to physical health by psychiatrists (weight, BP, etc.)
  - c. Inadequate training of PCP's regarding behavioral health
  - d. Stigma regarding behavioral health (from other providers)
2. Improved interdisciplinary collaboration
  - a. Lack of time/funding for collateral contacts (other psychiatric providers, psychologists, social workers, primary care providers, family members)
3. Communication/better transitions between levels of care (changes in medication management after discharge from hospital without communication with inpatient providers).
4. Confidentiality/HIPAA as barrier to collaboration with family and other providers.
5. Increased education
  - a. Better access to education about medications for consumers/families.
  - b. Greater knowledge about alternatives to medication.
6. Insufficient time for psychiatrists to meet with consumers. Psychiatric practice limited by constraints of system (15-20 minute "med checks").
7. Improved communication between psychiatrist and consumer (other mental health professionals indicate need to "mediate" this interaction).
8. Ways to engage/partner with individuals in denial of mental illness.

**Discussion Group # 6 Title: Cultural Competence:**

**Identified Needs:**

1. There has been a lack of clarity about what cultural competence means for psychiatric practice.
2. Recognition that an individual may have several cultural influences (i.e. ethnic, religious, sexual, occupational, etc), all of which may have significant impact on their beliefs and preferences.
3. Most psychiatrists have few skills for understanding cultural influences and how to help craft culturally appropriate interventions effectively.

**Recommendations:**

1. Define meaning of cultural competence for psychiatric practice and corresponding skill set to enable effective engagement of cultural issues.
2. Develop concept of culturally informed practice that incorporates a process of humble inquiry and learning that allows clients to assume the role of teacher.
3. Psychiatrists should assure that service plans are determined in the context of individual cultural influences
4. Increased awareness of disparities created by discrimination based on cultural identification and misunderstanding.

Discussion Group # F7 Title: Developing Clinical Teams

Identified Needs:

Reduce staff turnover on teams

Allow for more autonomy to foster creativity

Balance effort between crisis and recovery focus

Create intermediate level of care services between hospital and community

Need teams to transition people between adolescent and adult services

Recommendations

Redesign hierarchical makeup of administrative oversight

Increase training opportunities of teams by external sources and internally by team leaders (members) i.e. role playing

Case rate/capitated funding

Outcome based funding

Time limits for crisis intervention which will increase time for recovery based interventions

Add more teams.

Discussion Group # F8 Title: Stigma Reduction

Identified Needs:

1. People agreed that public attitude and language need to be addressed
2. Enforcement of the A.D.A.
3. Eliminating health disparity, e.g. MH and physical health
4. Targeting media, promote celebration
5. How to integrate "Peer Counselors" in environment where credentials are critical
6. Training, mentoring

Recommendations:

1. Responsibility lies within all stakeholders
2. Dependent/independent/co-dependent issue needs to be addressed.  
Redistribution of power.
3. SILO busting
4. Training needs for users and professionals
5. Media education; get involved with the budgeting and legislative process.

Discussion Group # F9 Title: Developing Resiliency in Distressed Communities

Identified Needs:

1. Universal Healthcare, insurance for everyone.
2. Prevention- keep people healthy.
3. Families need help
4. Primary care -in psychiatry too
5. Help to distressed community of psychiatrists - care givers

Recommendations:

1. Building resilience in professionals.
2. Build resilience to next disaster: connect with communities to engage them in readiness.
3. How to connect MHS with community: Work with schools to build resiliency, resilient children resilient consumers - resilient communities.
4. Home visits - outreach and community resilience.
5. Public health - prevention work with and relate to communities. Early intervention, screening, Parenting skills, .etc.
6. Try to learn from community :deficiency vs. sufficiency - change communication.
7. "Spirituality" has decreased - to tie it back.
8. Expand "cross training" to include community, not just other disciplines.
9. Social network as peer support, build capacity in social networks.

Discussion Group # F10 Title: Political Advocacy

Identified Needs:

1. Need for all constituency groups to be involved in political advocacy with a unified message.
2. Need to develop power to become agents of change.
3. Need to advocate for prevention programs and programs that work; disseminate information on the cost effectiveness of treatment.
4. Need for good information on where policy makes a stand and how they voted and getting that information out to inform people.

5. Need to use creativity and political advocacy to identify new ways of funding
6. Need to involve the media.
7. Need on-going relationships with policy makers to educate them on our issues.
8. Need for more political involvement - register and vote!

Recommendations:

1. We need to get the power to be change agents:
  - Register to vote
  - Voter education
  - Public education with a unified message
  - Works together to craft the same message to influence the political market place and the media - all the constituencies have to work together.
2. Need to involve the media to educate the general public and to address stigma. Use personal stories to illustrate success!
3. We advocate for all the constituency groups to be involved in these efforts together.

Discussion Group # F11

Title: Community and System Consultation

Identified Needs:

1. Training for psychiatrists in consultation; emphasis in residency programs.
2. Encompassing consultation as part of practice - including funding.
3. Involvement of all stakeholders in any consultation effort.
4. Position paper on role and practice for community psychiatry.
5. Leadership

Recommendations:

1. AACCP and others create position paper on what community practice is now and needs to be in the future.
2. Expand definition of consultation.
3. Develop methods to support.
4. Enhance leadership and group systems components of training.
5. Create model job description encompassing consultation.
6. Case conferences with clinical and systems consult in training.

Discussion Group # F12

Title: Transformation

Identified Needs:

1. Time to get to know the person behind the diagnosis, to do person-driven care planning, etc.
2. Integration/coordination of care to reduce duplication and fragmentation.
3. More psychiatrists interested in the work.
4. To look beyond mental health system per se to increase efficiency across sectors
5. Resources

Recommendations:

1. Integrated data bases across agencies and sectors (e.g., Philadelphia)
2. Change agency cultures to make everyone, including psychiatrists, feel welcome
3. Parity in funding for behavioral health care, restoring dollars shifted out of behavioral health (2% to 10% of overall health care costs)
4. Change financial incentives to promote recovery rather than disability, prevention rather than crisis response, etc.
5. Performance measurement to incentive/achieve desired outcomes and incentive/achieve customer service.
6. Medical directors can ... foster a culture of collaboration making people and recovery value clinical consultation, and clinical supervision. (flexibility in use of resources)

Discussion Group # F13

Title: Access in Rural Communities

Identified Needs:

1. Transportation
2. Increase access to psychiatrists for more choices
3. Stigmatizing of individual and their residences.
4. Cultural competency
5. Psychiatric recruitment
6. Limited (DPW enrollment) choices

Recommendations:

1. Place monies into budget/networking with different agencies to provide transportation and treatment to the patient. Mobile office. (mobile medication)
2. Tele-psychiatry model - certain limitations - question of reimbursement as a possible issue. PA will reimburse. Need someone in the room (therapist, MH worker) also, however, will only reimburse only amount of med. Check.
3. Mobile crisis
4. Integrate relationships with physical doctors and psychiatrists/acute care - local G. Admin. purchases beds from local hospital for bed space availability
5. Integration of psychiatry with clergy.
6. In rural or underserved areas - Federal Qualified Health Clinic - physical - behavioral - dental - pharmacy. Grants available \$600,000 start up money
7. Distribution of services/residency affiliation/lifestyle
8. Incentives such as loan repayments/find people who WANT to be in a rural area.
9. On-line training with DPW in order to access services in the area.

Discussion Group # F14

Title: Community Engaged Scholarship

Identified Needs:

1. Doctor to examine if what we are doing is effective
2. (and thus more funding)
3. Developing leadership nationally from community of psychiatry.
4. More academic leadership - loss of thoughtful productivity in JR faculty
5. Diverting funding stream towards academic psychiatry

Recommendations:

1. Community information → back to community → political
2. Reflect information back to community so they can be empowered to change
3. Focus on building your own networks.
4. Expose students to community psychiatry.
5. What could this organization do to promote scholarship in the community/membership?
6. What could the community of psychiatry do to move toward the scholarship of engagement?
7. Could we develop mentorship in academics for community engaged scholarship?
8. Look to network research NIMH
9. Deciding what is good scholarship. How can CBPR become better received?

Discussion Group # F15 Title: Collaborative Relationships

Identified Needs:

The group identified the following needs which can only be successfully addressed through collaboration.

1. **Ease of access** - Lack of connection in the public/private MH/SU as well as the physical health/MH/SU systems create complexities that are confusing and discourage use of services.
2. **Parity** - The group discussed the Oregon law which was recently passed. The strategy they utilized included trying the concept in the Public Employee benefit plan first. The results did not increase cost to the degree feared. There was a 0.5% increase the first two years and a 0.28% increase the third year. These results encourage the large insurers to participate as an advocate for the change.
3. **Payment system that supports collaboration** - Example: Regulations allow only one service to be paid per day. This makes it impossible for MH/SU services to be provided in a Community Health Center as part of an integrated visit.
4. **Eliminate Stigma** - The group discussed stigma as a significant barrier to change. Stigma prevents the open discussion needed to educate the public about the shortcomings of the system (including their own health insurance which they often do not realize until they need it).
5. **Collaborative treatment team** - This is a powerful treatment method which has been eroded by payment systems that encourage silos.

Recommendations

1. The group indicated that it is imperative the Payers and the Media be part of the collaboration as well as providers, families, consumers and government agencies.
2. The "Collaborative" should pick two to three things to collaborate on. Focusing on priorities will be most effective and powerful.
3. The three most discussed issues/priorities were:
  - Parity
  - Access
  - A payment system that supports collaboration, quality and access for all.

All agents of change listed would be needed. Community Psychiatrists should take a leadership role.

Discussion Group # F16

Title: Person Centered Service Planning

Identified Needs:

1. Clients need to be encouraged/taught/mentored on being a self-advocate.
2. A lack of coordinated treatment planning among agencies (factors include HIPPA, lack of communication, and managed care).
3. Skills in formulating person/recovery centered treatment planning (how to collaborate with clients, how to use jargon free terminology).
4. The current documentation overload scares providers from trying a new kind of "treatment planning".
5. The lack of strength based focus in clinical interactions.
6. Opportunities/venues

Recommendations:

1. Development of advocates/coordinators to cut across agencies, providers.
2. Enhance environments that foster collaboration between consumers and providers (more time for appointments, cross disciplinary time).
3. Encouragement of alternative treatment planning models that are strength focused, comprehensive/holistic (e.g. WRAP).
4. Institute training of providers/consumers on how to make recovery/personal centered treatment planning.
5. Formulate a "treatment plan" with providers. Carrying it themselves to overcome HIPPA burdens.
6. Ownership - simplify - unify

Discussion Group # F17

Title: Transition Management

Identified Needs:

1. Better communication between providers
2. Continuous planning and assessment
3. Transient relationships discourage continuity
4. Demand for quality in transition planning
5. Concurrent payment for overlapping services
6. Training in transition management not currently provided
7. Recovery/wellness/resiliency language (concept)
8. Funding for computerization

Recommendations:

1. Integrity, embrace recovery principles
2. Peer advocacy - proper incentive and scope of practice
3. Quality and performance standards
4. Training in transition management
5. Restructure resources
6. Designed systems to meet needs of client - preserve continuity
7. Recovery transition specialist, RN/MSW and peer advocate - case management, funded by county or MHSAS
8. Peer support - high level

Discussion Group # F18 Title: Recovery Oriented Practices

Identified Needs:

1. Change medical model of service delivery in which physicians occupy a position of authority and are the primary decision makers.
2. Reduce distance in relationships that create barriers to developing partnerships.
3. Current funding arrangements and large caseloads create environments that discourage the formation of meaningful relationships between consumers and psychiatrists
4. Participation by psychiatrists in a broad array of clinical management issues that promote recovery.
5. Training programs have not incorporated recovery-focused practices into their curricula
6. Research has maintained its focus on the brain rather than services.

Recommendations:

1. Training programs should incorporate recovery-enhancing practices into curricula at all levels and across all rotations.
2. Continuing education opportunities related to recovery focused practice should be strongly encouraged and should include opportunities to interact and dialogue with service users in non-clinical settings
3. Emphasize development of ability to recognize recovery oriented practices and how to measure them.
4. Establish leadership role in advocating for systems reform and recovery enhancing services, emphasizing consumer satisfaction and service.
5. Assume active role in developing a collaborative relationship with clients and developing recovery partnerships
6. Systems should support integrated services (breakdown silo organization) and consumer choice in service selection.
7. Systems should develop creative alternatives to current funding mechanisms and develop methods to extend psychiatrists' capacity to have adequate time with clients and to expand focus from medication management.

Keystones for Collaboration and Leadership: Transforming Community Psychiatry  
March 3-4, 2006 - Discussion Group Report

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Discussion Group # F19

Title: Integrated Care

Identified Needs:

1. Medical treatment model hinders involvement of others.
2. Identification and treatment of past trauma/PTSD.
3. Training of providers on counter-transference issues.
4. Availability/parity.
5. Use of motivational interventions/collaborative treatment model.
6. Listening skills for providers.

Recommendations:

1. Improve MH/D&A training medical professionals
2. Insurance parity

Discussion Group # F20

Title: Engaging Youth and Families

Identified Needs:

1. Youth (and family) admitting to having a problem
2. Overcoming stigma - barrier to acknowledging problems
3. Parent's difficulty accepting loss associated with Dx
4. Lack of attention to mental health needs of students in school
5. Lacking of willingness/ability to engage in a humane way on part of professionals
6. Lack of advocacy for child/family (need parent advocates)
7. Blaming parents
8. Lack of adequate time to engage fully
9. Failure to understand adolescence and adolescents with mental health problems as liable to express these behaviorally

Recommendations:

1. Natural coming together of families with mutual problems
2. Appointments and/or advocacy meetings on evenings/weekends
3. Peer support advocacy for both youth and their parents
4. More awareness of mental health problems of students in schools and service supports
5. Talking to youth, asking them what they want
6. Instilling hope as a mental health professional by the way we interact and attitudes
7. Using a strength based approach to treatment
8. Giving youth choices, explaining options/consequences
9. Using praise - noting and celebrating small steps
10. Express willingness to persist with a youth even if setbacks and disappointments
11. Parents have a right to enjoy their child, help them to do so

Discussion Group # F21 Title: Disaster Preparedness

Identified Needs:

1. Need to address needs of people with mental illness and role of medication
2. Education to community about basic disaster issues and disaster mental health
3. Credentialing and licensing issues related to disasters
4. Self care of mental health providers in disasters
5. Greater awareness of cultural needs in disasters

Recommendations:

1. Need to educate patients and providers in disaster preparation skills
2. Encourage liaison continuity plan for mental health agencies.
3. Town hall and public forums for education
4. Explore medical reserve corps issue. Also consider nationalized/federalized response
5. Educate providers to do evaluate self care issues
6. Education of cultural needs and empowerment of groups in disaster mental health response process.

Discussion Group # F22 Title: Health Disparities

Identified Needs:

1. Getting psychiatrist interested and keeping them learning and moving on learning.
2. Train psychiatrist to advocate.
3. Provide adequate reimbursement
4. Clearer definition; access to services or broader issues

Recommendations:

1. More time, part time for training, part time with consumers, then place in community.
2. Provide adequate reimbursement and more time.
3. Have  $\frac{1}{2}$  of staff be trained while working the others are working with consumers.
4. More jobs.

Discussion Group #23 Title: Homelessness and Housing

Identified Needs:

1. The major need is supportive housing. People that are chronically homeless need to have access to housing options of their choice
2. Lack of affordable housing
3. Connecting the chronically homeless to the appropriate level of supports and housing
4. Difficulty accessing funding streams for a broad range of supportive services that an ACT/clinical team can offer.
5. Lack of well-trained and experienced staff, including psychiatrists
6. Fewer restrictions by payers about how mental health services can be delivered in the community setting, greatly hampering clinical teams' ability to be flexible and creative in meeting the needs of this challenging population.

Recommendations:

1. Improve training on impact of poverty and homelessness on mental health issues.
2. Enhance clinical techniques in engagement of hard-to reach populations and understanding how to work and have clinical leadership in nontraditional service settings
3. Expanded role of advocacy in work with homeless populations; more involved with homelessness policy at the federal, state, local, and provider level
4. More research about the impact homelessness has on mental wellness
5. Focus more on mental health issues concerning homeless families in that in most communities the great majority of homeless people are family members, not single adults.
6. Reduce barriers to affordable housing.
7. Better screening for homelessness at healthcare and other institutions, and disposition plans that do not include d/c back to homelessness.
8. Flexible funding at federal, state, local level.
9. Development of respite centers for people that are homeless and have mental health issues.

Discussion Group # F24

Title: Correctional Systems and Psychiatry

Identified Needs:

1. Need for continuity of care between in jail/prison providers and community providers.
2. Need for cross-training/skill building between mental health and criminal justice systems.
3. Need to collect, analyze, and share data for both quality improvement and research/evaluation.
4. Need to be extra concerned about stigma/discrimination in justice-involved people with mental illness/S.A.
5. Need to have better funding for treatment services.

Recommendations:

1. Providers should "think like a mom" and focus on care and support. Community must define inmates/clients as our common concern.
2. Develop a continuum of support and transitional services, including creative interventions for criminalgenic thinking (look at Allegheny model).
3. Train law enforcement, corrections and dispatch staff on how to recognize and respond to persons with behavioral problems.
4. Use Peer Support as part of engagement/recovery plans.
5. Start early intervention/prevention with juvenile justice and youth populations.
6. Break down silos, look for efficacies and joint funded opportunities.
7. Change legislation to ensure Medicaid benefits are suspended, not terminated on incarcerated.
8. Re-entry planning should begin on entrance (transition).
9. Need spirituality based programs.
10. All contact with justice involved persons with mental illness should be trauma informed.

Discussion Group # F25

Title: Quality Improvement

Identified Needs:

1. Clear goals
2. Clear methods
3. Identification of resources (time and money)

Recommendations:

1. Emphasis on collaboration and reimbursement for time
2. Recruit/retain quality staff
3. Good supervision/mentoring
4. Recognition for staff

Discussion Group # F26

Title: Resources - Need Management

Identified Needs:

1. Match funding to need, e.g. cover uncompensated care; keep systems afloat.
2. Allow for care to a continuum, allow for rehabilitation/recovery.
3. Shortage and aging of psychiatrists; attrition ten times greater than new members.
4. Fees don't match needs; payment drives service.
5. Employees need to see value of treatment; be part of it.
6. Lack of resources for support.
7. Lack of access to appropriate levels of care (e.g. housing, job resource, lower wages of consumers).
8. Resource amount, method, cost shifts, institutionalization of uninsured, this system is about to break.
9. Change political-social dialogue, parity; stigma.
10. Reduce administrative burden.
11. Leadership: example of implementing this change, knowledgeable.
12. Integrity and accountability, M.D. critical

Recommendations:

1. Change payment methodologies to support qualitative, efficient change and recovery.
2. Get a strong leader, medical director, with networking skills; good knowledge of care continuum; credibility across all domains, corporate and public; has integrity.
3. Implement performance based change, methodologies and components of care; compare/benchmark with status.
4. Build a system that better reflects the "rights of everyone to be well." Values of American people.
5. A mental health Bill of Rights.
6. Strengthen the recovery based model to care with services, e.g. housing, detox, vocational rehab.
7. Build a system capable of addressing earlier prevention and intervention ...earlier inroads.
8. Address resource shortage: funds and workers.

9. Create payment methodology that reinforces recovery, quality and efficacy and accountability.
10. Improve vocational rehab, quality first.
11. Child and adolescent services, too on too much (BHRS)
12. Build a system capable of prevention and earlier intervention of child, adolescent and adult care.
13. Build performance measures that can support and "lend" , best practice change.
14. Employer education of effectiveness of treatment; de-stigmatize and build business case.
15. Build leadership with consumers, employers, payers, providers...leadership for change, skilled networking

Discussion Group # S1

Title: Refining Psychiatry

Identified Needs:

1. Too much focus on healthcare in general in U.S. life
2. Suffering - focus on patient, not paperwork
3. Data as to most financially useful interventions
4. Not enough time to do the transformation
5. Address demoralization
6. Macro issues: social and theoretical/economic (dollars)
7. Dehumanization
8. Leadership (lack of)
9. Demoralization of staff
10. Fear of uncertainty

Recommendations:

1. Developing hope in psychiatrists
2. More visible agenda nationally
3. Coalition of consumers and providers
4. Focus on the human aspect of psychiatric care
5. Dialogues on a local level
6. Hope of new networks and active movements.
7. New alliances with consumer/ex-patient
8. New alliance with and social scholars
9. Embrace uncertainty/doubt
10. Self-knowledge and exploration
11. Re funding allocations

Discussion Group # S2

Title: Developing the Psychiatric Workforce

Identified Needs:

1. Money for direct service folks for more complex tasks (MH, medical problems)
2. Money for training; billable hours vs. attending trainings
3. Training - books vs. experiential
4. Lack of commitment to public service/ lack of mentorship role models
5. Dissatisfaction doesn't engender promotion
6. Leaders don't stay to train you, have lost touch with patient care
7. Lack of leadership
8. Lack of continuity
9. Stigma
10. Safety
11. Sickest people get the worst care.
12. Credentialing/training/background of case management worker pool.
13. Lack of on-going onsite clinical supervision; not trained to do supervision.
14. Lack of value agency gives to clinical front-line staff.

Recommendations:

1. Start younger at recruitment (teaching social values)
2. Advocacy - help decision makers understand the need for funding
3. Funding - Case rates
4. Role models; promote them and put them out there for students to see.
5. Capitated rates/case rates - to allow for flexibility within the funding stream. Block grant vs. billable service model.
6. Advocate for high education and more flexible funding.
7. More interaction between consumer, family members, and trainees/professionals.
8. Retain in recovery; CME about recovery
9. Integrated systems follow patients/clients throughout time and their ups and downs so you as staff can see recovery.
10. Creative stipends
11. Student loan repayments
12. Pay for peer supervision/case presentations
13. Reward people who are innovative and creative (creative programming and leadership); plaques, dinner, thank you

Discussion Group # S3

Title: Spirituality and Psychiatry

Identified Needs:

1. To better define the spirituality-religion dimension.
2. To confront the myth of values-free therapy/rehabilitation.
3. To increase dialogue between faith and treatment communities
4. To increase education regarding spirituality and healing in graduate schools.
5. To make it acceptable for clinicians to raise the issue of spirituality in treatment.

Recommendations:

1. Find and present models where spirituality is already being integrated into treatment.
2. Open some dialogue between faith and treatment communities.
3. Encourage in spirituality/religious approaches and in therapy to speak in each other's venues.
4. Give consumers assistance in connecting with faith communities.
5. Emphasize in treatment programs the spiritual core of all persons.

Discussion Group # S4

Title: End of Life Care

Identified Needs:

1. Doctors don't like death.
2. Dying at home vs. inpatient hospice/hospice in general hospital
3. Death across the age range.
4. Legislation:
  - a. End of life protocols - nothing about special populations
  - b. Advanced directives
  - c. Appointment of a surrogate (Healthcare Power of Attorney)
  - d. Medicare: palliative vs. behavioral health
5. Issues of competency

Recommendations:

1. Rationalize and coordinate funding of care, regulations for decision making.
2. Greater sophistication in recruiting end-of-life issues in children.
3. Pain management:
  - a. End of Life
  - b. Dually diagnosed
4. Look at end-of-life issues in residential (provider) system.
5. Education in medical schools, residency programs nursing school, social work, etc.
6. Broader community education.

Discussion Group # S5 Title: Engaging Consumers, Supporting Peer Support

Identified Needs:

1. Peer support groups in rural areas.
2. Brain injured persons peer support groups.
3. Clearing house for peer support groups.
4. Material support and/or certification for consumers who run these groups.
5. Consumer voter registration and political empowerment.
6. Recruitment
7. Accountability
8. Non-judgmental atmosphere

Recommendations:

1. Training programs for setting up peer support system. (S,U)
2. Voter registration drives (S,U)
3. More drop-in centers
4. Informal peer support groups
5. Formal peer support groups
6. Peer/professional collaboration

Discussion Group # S6

Title: Developing Child and Adolescent Systems of Care

Identified Needs:

1. Address regulatory barriers around funding/roles.
2. Address
3. Training for participation in systems of care
4. Parent and youth involvement for advocacy and system accountability
5. Increased developmental/
6. Problems with adequate time by professionals to actually implement interventions and program.
7. Disconnection of drug and alcohol services from mental health programs.
8. Systems of care in rural/suburban communities.
9. Greater involvement by education in systems of care.
10. Lack of service for SPMI parents and their families and older youth.
11. Lack of integration of into child mental health issues and collaboration (either hesitation to provide and coordination of other services).

Recommendations:

1. Blended/braided funding with "back room" functions for funding accountability.
2. Flexible service roles.
3. Values integration across agencies - reflect missions/roles of different agencies (beyond CASSP Principles /education.
4. Generalist training for system of care skills along with specialist skills. Need advanced training and pre-service training.
5. Parent and youth organizations to train parents/youth to promote advocacy.
6. Less diagnostic approach and inclusion of at-risk for early childhood prevention services access.
7. Adequate staffing and staff time for service provision, particularly collaboration time and planning time.
8. Integration of drug and alcohol services.
9. Stimulate bottom-up grass roots system of care development using natural resources for services development and use of tele-psychiatry.
10. Promote partnerships with education that shares burden of service delivery, using IEP process (like MN and CALIF).

11. Use educational settings to develop preventive services (skills-building, screening at-risk, education interventions).
12. Need adult mental health as system of care partner for parent of SPMI and youth.
13. Integrate PCP's into Systems of care, including outreach, co-management/ , and support of PCP's (including co-location with PCP practices), identity leadership in pediatrics for systems of care. Also change structure for psych-pedi consultation (ST, MA)
14. Pediatric Advocacy Alliance ( mental health advocates with pedi illness advocate.

Discussion Group # S7

Title: Primary Care and Psychiatry

Identified Needs:

1. Financing
2. Practice challenging
3. System of care, how to connect pieces of continuum

Recommendations:

1. Need funding flexibility - pay for non-direct.
2. Training for PC providers - to know what possible to manage patients with behavioral health needs
3. Technical assistance to PC providers
4. Work on connections between PC and rest of mental health continuum - referral to more intensive care
5. Stigma - people need not be afraid to get care