Psychosis in public mental health: Provider perspectives on clinical relationships and barriers to the improvement of services

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Psychosis in Public Mental Health: Provider Perspectives on Clinical Relationships and Barriers to the Improvement of Services

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Whereas a growing literature has sought to understand challenges involved in the dissemination and implementation of specific evidence-based practices (EBP), few studies have centered on the perspectives of front-line community providers regarding best practices, clinical ideals and barriers to quality improvement for clients with psychosis. The goal of this project was to lay a foundation for future work aimed at improving the overall quality and impact of the multifaceted services typically provided to adults with psychosis served by the public mental health system. The findings reported here draw on a series of in-depth interviews and focus groups with 34 clinicians based at multiple inner-city community mental health sites. The project was participatory and service user co-led. Analyses focus on participant’s perspectives concerning optimal services for clients with psychosis and perceived barriers to improving services. Providers strongly underscored the centrality of relationship quality versus mastery of specialized techniques and of deeper experiential engagement with the subjective meaning of the experience of psychosis. Asked about barriers to quality improvement, they described both macrolevel social forces, including chronic underfunding and overreliance on manualized approaches to distress, as well as cross-cutting clinical challenges not typically captured in the literature on more specific, targeted interventions. Our discussion focuses on the implications of these findings with respect to research and quality improvement and concludes with a call to increase investment and attention to the perspectives of front-line providers and the issue of workforce and organizational capacity vis-à-vis psychosis.

Public Policy Relevance Statement
While a significant amount of research has focused on the effectiveness and implementation of specific interventions for psychosis, policy, and/or programmatic work designed to bolster capacity and quality across a given agency or set of linked services has received much less

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n recent years, community mental health (CMH) researchers have placed increasing emphasis on the investigation of barriers to the implementation of specific, generally evidence-based, interventions or approaches, a field often described as “dissemination and implementation science” (DI; Schoenwald, McHugh, & Barlow, 2012). Critics of conventional DI, however, have expressed concerns regarding an overemphasis on “already packaged programs”—often interventions developed in academic settings with resources not commonly available in the community, rather than similar community settings (Atkins, Rusch, Mehta, & Lakind, 2016; Weisz, Ng, & Bearman, 2014)—and overly rigid fidelity protocols and criterion. This critical body of literature has also drawn attention to specific disconnects between community and academic sites including differences in organizational capacity (Kelleher, 2010), the training and supervision of providers, and ecological misalignment between at least some academic intervention development and testing and the constraints of underresourced public mental health agencies (Santucci, Thomassim, Petrovic, & Weisz, 2015; Weisz et al., 2014).

Disconnects between intervention research and everyday clinical practice are further foregrounded in studies documenting practicing clinicians’ often skeptical attitudes regarding the usefulness of academic research (e.g., Stewart & Chambless, 2007; Stewart, Stirman, & Chambless, 2012). Drawing on in-depth interviews with practicing clinicians, for example, Stewart and colleagues (2012) conclude that providers can harbor significant doubts about the applicability of findings from clinical trials to their clients as well as concerns about the potential misuse of research findings to narrowly dictate rather than inform clinical practice. A survey project aimed specifically at active researchers who simultaneously maintained a clinical practice found similar attitudes: empirical research was still rated as less helpful than a wide variety of other sources of information, including direct clinical experience and learning from clients (Safran, Muran, & Eubanks-Carter, 2011). Other research suggests that even when relatively rigid practices are ostensibly mandated by policy, providers tend to adhere to their own clinical values and to continue to practice with greater flexibility than policy dictates (Arnd-Caddigan, 2012).

Common factors theory, which holds that much of the effectiveness of ostensibly diverse therapeutic approaches (and specific evidence based practices) in fact stems from common underlying factors arguably complements the above findings (Barth et al., 2012; Blow, Sprenkle, & Davis, 2007; Laska, Gurman, & Wampold, 2014), redirecting attention to cross-cutting processes and dynamics thought to undergird change. Laska et al. (2014), for example, argue that the overall impact of such factors as client-therapist consensus over goals and methods, empathy and trust, and affirmation account for substantially more of the variance in client therapy outcomes that the specific treatment method or approach. A recent analysis of the impact of therapeutic alliance (TA) on outcomes in response to cognitive–behavioral therapy for psychosis (CBTp), for instance, found that therapeutic alliance actually exerted a causal effect on outcomes: with good TA attendance of more sessions improved symptomatological outcomes, whereas poor TA combined with good attendance was actually detrimental to the service user and exacerbated psychopathology (Goldsmith, Lewis, Dunn, & Bentall, 2015). From an ecological perspective, common factors such as therapeutic alliance do not arise in an interpersonal vacuum, but are instead shaped by the social and structural contexts in which the provider and the service user are embedded. These contexts include the clinical supervision of the provider (Rousmaniere, Swift, Babins-Wagner, Whipple, & Berzins, 2016), the organizational culture in which clinical interactions occur (Hemmelgarn, Glisson, & James, 2006), and the service user’s history of attachment-related trauma (Lysaker, Davis, Outcalt, Gelkopf, & Roe, 2011) and structural disadvantage (Smith, Li, Dykema, Hamlet, & Shellman, 2013).

**Psychosis in Public Mental Health**

A separate set of issues is relevant to the examination of public mental health services for persons with psychosis more specifically. Whereas many evidence-based practices in the field of clinical psychiatric rehabilitation have been developed and tested in samples with high rates of psychotic disorders—for example assertive community treatment, individual placement and support, and integrated dual diagnosis treatment—therapeutic approaches...
specific to psychosis such as cognitive–behavioral therapy for psychosis (CBT-p), remain widely underimplemented and/or unavailable in the United States, particularly in community settings (Mueser & Noordsy, 2005; Riggs, Wiltsey-Stirman, & Beck, 2012). In contrast, specialized early intervention in psychosis services have begun to take hold over the past decade (Dixon, 2017); however, inclusion is generally limited to a two-year period following initial onset. Standard adult mental health services typically provide generalist programs targeting such areas as independent living, substance use issues, or general well-being, rather than providing specialized clinical interventions for psychosis. While we were unable to locate research specifically focused on longitudinal changes in the overall balance of therapy and medications accessed by persons with psychosis in the United States, research on trends in the treatment of mental illness more broadly suggests that access to therapy has remained flat while the use of psychotropics only (without psychotherapy) has substantially increased (Olfson & Marcus, 2010).

The Current Project

Although the literature reviewed previously provides a strong rationale for research attentive to the broader contexts of public mental health, there is a surprising scarcity of publications focused on factors and constraints shaping therapeutic engagement with individuals with psychosis and their experiences within the U.S. public mental health sector. The major aims of the work described here were to better understand provider’s:

1. values and ideals with respect to working with/serving clients experiencing psychosis;
2. current state of services and perceived barriers to improving these services for clients with psychosis.

In the context of the existing literature, our goal was to lay some of the initial groundwork for intervention and/or policy changes needed to improve the overall experience of the typically multifaceted and multicomponent services received by clients with psychosis served within the public mental health system and ultimately their impact.

Method

The research described in this article is grounded in four focus groups with 32 front-line clinicians, and 2 additional individual interviews with senior administrative and/or training staff unavailable for the focus groups (total n = 34). All research was approved by the DePaul University institutional review board (IRB MS12012NUR-R4), and all clinician participants provided informed consent. Interviews were conducted as the second phase of a two-year project, with Year 1 entailing approximately 100 hr of ethnographic observation by the first author, including shadowing assertive community treatment home visits, attending therapeutic groups, attending provider trainings, and spending extended periods at drop-in centers and residential programs. The ethnographic component of the project was designed to provide deeper insights into the contexts in which providers worked and while ethnographic findings are not reported in this paper, they provided important context to understanding and interpreting the subsequent qualitative work. Recruitment entailed purposive sampling, driven by the senior provider-based project lead. Specifically, efforts were made to conduct focus groups with providers from different program areas, and with varying levels of experience and expertise. Two of the focus groups involved entire community support teams, one consisted of more senior leadership as well as supervisors from multiple programs, and one consisted of all current doctoral-level clinical psychology interns at the agency. Agency leadership handled recruitment as well as the scheduling of interviews; the first author led all focus groups.

The project utilized robust participatory methods with all research decisions shaped by a research advisory board (RAB) that included both clients (service users) and providers and that met monthly throughout the project lifecycle. For example, the RAB helped determine who should be included in focus groups in order to maximize the diversity of views and experiences, collaboratively designed specific questions and reviewed the focus group guides. A subset of the members of the project RAB also participated in the ongoing work of interpretation and analysis—for example, reading and revising multiple versions of the article.

The clinician focus groups and interviews centered on participants’ clinical goals and values vis-à-vis psychosis (“please describe your approach to working with clients with psychosis”), their understanding of optimal engagement with clients and the experience of psychosis (“what do you think it means to engage with clients and their experiences”), personal challenges (“what do you personally find most challenging about working with clients with psychosis”), and perceived barriers to quality improvement (“what do you see as the major barriers to improving services for clients with psychosis within your program”). Protocol questions were open-ended but explicitly included multilevel prompts to elicit clinician participants’ views on broader policy and systems-level factors as well as interpersonal variables. Focus groups were audio-recorded.

Following data collection, recordings were transcribed verbatim and integrated with additional notes that captured nonverbal information such as nods, raised hands, and other nonverbal indications of agreement. In many cases, these nonverbal communications were used to gauge the strength of particular themes and their resonance with other participants (and are noted as such in our analyses). The transcripts were coded using a constructivist grounded theory approach (Charmaz, 2014), with a focus on identifying core underlying themes (that in many cases cut across the discussions following different questions). The first author and a research assistant each independently coded two focus group transcripts, discussed coding and arrived at a semifinal coding schema by consensus. The themes were then refined in dialogue with the original RAB. After a further round of reliability checks, all transcripts were coded by the first author. In reporting findings, we have numbered participants in order to distinguish comments from different individuals (e.g., Clinician 1, Clinician 2, Clinician 3).

Agency Context

The host community mental health agency (CMHA), employs over 500 staff covering a large urban center as well as suburban areas, spanning multiple counties. Clients served by the agency virtually all met criteria for “severe mental illness” and receive public benefits tied to significant functional disability. Approxi-
ultimately three quarters of the agency’s services are provided in the community, with staff generally working as part of a team to meet a range of service user needs. The CMHA also runs residential and transitional housing programs, and fieldwork for the project was split between residential sites and the shadowing of clinicians on home visits. A typical day for a community-based team member might consist of 2–4 outreach visits, potentially including activities such as grocery runs or transportation to a physical health appointment. For staff at residential sites, daily work would typically involve a combination of cooking with residents, outreach oriented toward locating housing or external supports, as well as individual planning meetings and peer support, social skills, or therapeutic groups. Just over half of the agency’s total staff have a bachelor’s degree or less, with the remaining clinicians possessing a master’s degree, typically in social work or counseling.

Results

Sample

Clinician participants consisted of 6 men and 28 women adults representing different CMHS sites and programs; all provided either front-line community-based clinical care and outreach or direct supervision of front-line community-based workers. With the exception of three doctoral level clinical psychology trainees, no other staff provided office-based therapy; instead, even those clinicians with substantial psychotherapeutic training were responsible for a range of broader community case management services including in-home medication management, service coordination, and provision of specific evidence-based practices in the areas of employment and illness self-management. The majority were Caucasian (82%), and the average age was 35. Three participants were clinical psychology doctoral interns, 1 working clinician had a clinical psychology doctorate, 5 were bachelor’s level mental health workers, and the remainder were master’s level clinicians with degrees in either social work, counseling, or nursing. Five of the participants were designated team leaders and/or clinical supervisors.

Qualitative Findings

Findings are organized into three overarching categories: (a) service and engagement values (or participant’s clinical ideals); (b) detrimental macrolevel constraints on service quality (structural and political reasons why clinical ideals may go unrealized); and (c) more proximal clinical challenges tied to the multifaceted, multicomponent nature of holistic adult behavioral health services.

Service and Engagement Values

Centrality of the therapeutic relationship. Overall, clinician participants repeatedly reiterated their belief in the therapeutic relationship both as the foundation of quality services as well as a fundamental element of practice and ultimately outcome. That is, relationships between clients and providers were frequently described as a scaffolding in which the dynamic alchemized a positive outcome, for example:

Clin 1: “so much of a human being’s psychological well-being is based off of being able to have meaningful relationships with other human beings. If you’re not able to do that, then anxiety, depression, delusions, psychosis can very easily set in for anyone. So to be able to use the tools that we have and to help people to increase their ability to be authentic and vulnerable in more situations is super beneficial. I think that the best way to do that is to model it ourselves [through the relationship].”

Clin 2: “For me, in any clinical work that I do, I take it as an approach of ‘we’re in a relationship together.’ I am a human being in this, you’re a human being in this, together we create something that hopefully changes me, and it also changes you.”

In contrast, particular techniques or practices (e.g., specific forms of therapy, tools, or manualized practices) were described as secondary and best used in a flexible way—for example, “as needed” or “as they appeal to the service user.” Similarly, clinical intuition, rather than specialized knowledge, was repeatedly invoked—“it’s less a matter of having formal skills or techniques than it is an intuitive understanding, attunement to people” explained one, while others referenced “an intuitive sense” or “intuitive abilities.” Participants also affirmed a strong belief in personalized support: “I think not just approaching it in just one-size-fits-all [way], like here’s the intervention that’s been shown to work, but, what does this mean for that specific person? What does that feel like to you, to be walking around with that?”

Engaging with the subjective meaning of psychosis. Taking an emphasis on relational quality one step further, many clinician participants explicitly emphasized the importance of engaging not only with the “normal” aspects of clients (i.e., as people) but also with “the meaning of their [psychotic] experiences,” including perceived connections to life events, and voice or belief content tied to cultural, spiritual, and/or political experiences and convictions. As a psychology intern in one group explained: “A lot of us have this notion that it’s our job to get them to come back to reality, that it’s our job to get them to speak our language, but a lot of us don’t take the time to speak their language and to enter the delusion—not in a way that reinforces it or enables it, but in a way to really understand what it means for the client. [When I encounter some new and challenging symptom] I’m not, ‘Oh, my gosh, I haven’t done this before. Let me step back and read a couple books before I intervene.’ It’s more of a way of just interacting with the person.” “The making meaning piece,” participants in a different group concurred, “is just—it’s essential.” Cutting across these discussions of meaning was a belief that psychotic symptoms must be taken seriously—that is, understood as experiences that should be explored and discussed on the client’s own terms.

The Current State of Services Vis-à-Vis Clients with Psychosis Within Their Agency

Detrimental macro-level constraints. Ultimately the bulk of conversation across the focus groups and interviews re-
volved around perceived macrolevel as well as more proximal clinical and interpersonal challenges (covered in the final section). While the macrolevel constraints are broken down into subthemes for clarity of presentation, in the focus group conversations it was clear that these were understood to be interconnected and synergistic, at turns driving and/or reinforcing one another. Subthemes are: the broader sociopolitical marginalization of serious mental illness; constraints imposed by billing and funding mechanisms; staff preparation; and the mechanization of behavioral health interventions.

Ripple effects of broader societal marginalization. Clinician participants consistently invoked the broader marginalization of serious mental illness—reflected in societal stigma and media representation, funding allocations relative to other social issues, provider compensation levels and perceived status, minimal training in serious mental illness in clinical training programs across disciplines as areas of major structural drivers of policy and practice. While funding itself was perceived as the single biggest issue, participants described a number of synergistic ways in which underfunding helped engender other forms of marginality. For example, public mental health services in their metro areas, participants noted, tended to be concentrated in defined “service ghettos”—typically parts of town with high rates of violence and crime, crumbling infrastructure, and food deserts. The location (and state) of these programs, in turn, served as a barrier to recruiting and retaining staff. “There’s some places people just aren’t willing to work,” one manager explained “or at least not many people.” Another described bed bugs as “a very real risk” for outreach workers, and participants noted that even some service sites were infested, and staff had to be instructed to take steps to reduce infestations of their own cars, bags, or gear. One clinician described recent gang violence in the area surrounding her program noting that “the staff get to leave but the [clients] don’t” and wondering aloud “what does that constant risk of violence do to people who already experience paranoia.”

Billing. Standard, contemporary billing practices were also widely viewed as an impediment to quality care. Clinician participants repeatedly noted the negative consequences of clinical productivity targets and quotas, including the amount of time spent documenting services and/or justifying medical necessity rather than meeting with clients, widely viewing such expectations as particularly detrimental to clients with psychosis for whom more time might be needed or to build rapport and gain trust. While their frustration was evident, many participants nevertheless conveyed an air of resignation in that: “Funding structure doesn’t allow it [deeper and more innovative practice].”

Explaining the erosion of funding over time, a senior clinical administrator noted that “Staff are now not [even] able to visit people in the hospital, can’t go to their funerals, because it’s not billable. Your job is to serve this function and who cares about the humanity. We try to find ways to let people go [e.g. to funerals], but it means we have to swallow the costs because the time is not covered.”

Staff preparation and retention. Clinician participants across all our clinician focus groups—but particularly supervisors—also emphasized the challenges of recruiting and retaining talented clinicians in the context of public mental health. A senior clinical administrator described those experienced, senior staff with the possibility to work outside of CMHS for greater pay who had nevertheless opted to remain in the public sector as a “select group” who “actively choose to serve the folks with the highest needs.” Consequently, administrators must grapple with a mix of the very talented individuals with the majority of staff entering the system with little to no experience working with psychosis. As one senior clinician noted, much of the counseling curricula for local master’s programs revolves around mild depression, anxiety, and adjustment issues “nothing like what many of [our agency’s] clients are facing.” Clinicians hired from other local agencies, in-the-field training and clinical supervision were described as typically neutral at best, and at worst, as having encouraged negative attitudes toward those with more stigmatized conditions such as psychosis: “not only do we have to teach them what to do, we also have to undo a lot of past learning that has led to an entrenched belief in chronic disability.” Only three participants noted any dedicated training in clinical work or therapy specific to psychosis while in graduate school: in one case a single-day workshop and for the others courses or supervision by instructors who “happened” to have an explicit interest asked about continuing education opportunities. Most participants described going years without a single psychosis-related CEU having been available. Interestingly, many welcomed and praised a recent new internal training revolving around an auditory hallucination simulation exercise indicating that staff interest in such topics is high.

Perceived Barriers to Improving Services for Clients With Psychosis

The mechanization of clinical work and intervention. Clinician participants also commented on the changing landscape of clinical best practices, in particular reporting what they perceived as the increasing mechanization, manualization, or “reductionist” tendencies of contemporary clinical policy.

Reflecting on contemporary trends, for example, participants in one group reflected:

Clin 1: “To be good at [working with voices/psychosis], a certain amount of [struggling together] is necessary.”

Clin 2: “It’s a more relational way of working.”

Clin 1: “Right.” [Multiple participants sigh in agreement, shake their heads]

Clin 3: “Somewhere along the way that got taken out of the mental health field, and more behavioral approaches where the service user is seeing somebody that delivers an intervention [took over], but really—”

Clin 4: “Then you measure it.” [Multiple members shake their heads, sigh]
Similarly, the increased emphasis on community-based services had, on the one hand, increased certain kinds of intimacy (e.g., visiting clients in their home) but reduced the casual interactions, and “getting to know one another” opportunities common when the majority of services were provided through day-programs, drop-in centers, or residential facilities.

Proximal challenges and constraints. Moving down to the level of interpersonal (micro) interactions and contexts, participants laid out two major areas of difficulty with respect to the improvement of services, relationships, and engagement with clients with psychosis (and with their experiences): (a) balancing more basic needs (and the service models designed to meet them) with “deeper” clinical work and (b) negotiating boundaries as providers move across the different roles and activities that increasingly characterize best practice, team-based services.

Balancing basic needs and clinical work or therapy. Providers were acutely aware of the extent to which their clients struggle with basic needs, including food and housing, as well as lack of transportation, and de facto segregation in services and/or disadvantaged neighborhoods. They nevertheless repeatedly affirmed a belief that deeper healing remained critically important. “The trick,” observed one, “is how do you take all the stuff you learned in grad school and utilize it in whatever you’re doing, as you’re helping someone clean their toilet? As you’re helping someone?” Different emphases emerged across the groups, with one set of providers, for example, calling for more dedicated one-to-one therapy and a reconfiguration of services to facilitate a “two tiered system” in which “we have people who do case management and care coordination and we have people who do therapy,” while others simply described the challenge of balancing both kinds of needs:

Clin 1: “We’re sometimes so geared toward making sure that other things are done as far as the housing is stable, other personal needs are taken care of. Not that the psychosis comes second; but the safety, the housing, food, all of those things are priority. Sometimes that overshadows the work that I was trying to do as far as the clinical part.”

Clin 2: “When I do more counseling-focused interventions, then I feel like it comes back to bite me in the butt the next day when I’m like, “Oh, crap, I didn’t call that 1–800 number for the Link card because I did this intervention instead.” Sometimes it’s like which one do they need more?”

Several participants also noted that while team-based models (e.g., assertive community treatment and other community support team frameworks) worked well in meeting holistic basic and functional needs, they were less sure that such models were conducive to more therapeutic work. As one explained: “We go see people maybe two, three times a week, and it rotates who we see. It’s tiptoeing a lot, I would say, cuz I feel like the longer we know [this service user], the more you are involved in the delusions. Sometimes she talks to me as if I just know. Yeah, it’s a tricky dance that we do.”

Supervisors could provide at least some guidance navigating these challenges, but clinician participants noted, little or any of their formal training had prepared them for such challenges, and they were unaware of any continuing education aimed at increasing skill sets focusing primarily on psychosis. Specific manualized interventions many were aware of, implemented, and/or had trained in, one participant observed, “just don’t go there.”

Negotiating boundaries across multiple roles and spaces. Clinician participants emphasized the unique challenges negotiating multiple distinct roles crossing the areas of counseling or clinical intervention, housing support, care coordination, daily living, and self-care with clients experiencing psychosis. For example, on any given day, a community team member might end up helping a service user dose out their meds for a week, or assisting with purchasing contraceptives, as well as engaging in therapeutic work. In particular, the transversal of different clinical and interpersonal boundaries and spheres of intimacy was viewed as particularly challenging. As one participant explained, “I had another member say to me before, he’s like, ‘Well, we’re friends, right? Because I ride in your car with you, and you let me pick the radio station, and you take me out for coffee.’ Boundaries definitely get blurry.”

In each focus group, at least a subset of participants drew a more explicit link between the multiple roles they held and risk of finding themselves integrated into clients’ (ostensibly delusional) belief systems. Examples provided included clients who “recruited” (or attempted to recruit) the staff member into helping protect them against other systems workers, for example general physicians or parole officers, whom they thought had placed them under surveillance, and those who reported voices that claimed very specifically that certain staff members were friends, saviors, or enemies.

Clin 1: “[A service user] told me the other day, he was like, ‘You’re an angel, and God is speaking to me telling me to marry you.’ Now he’s calling me all the time cuz he says that God told him to be in love with me and marry me. [I do not know what to do.]”

Clin 2: “I was fortunate enough for a while to never be included [in any service user’s delusions]. Then one day, out of nowhere, it happened. . . . it feels like tiptoeing a lot, I would say, cuz I feel like the longer you know [this service user], the more you are involved in the delusions. Sometimes she talks to me as if I just know. Yeah, it’s a tricky dance that we do.”

Clin 3: “A guy who was a voice hearer, and one of his voices ended up being my voice, was saying things that I wasn’t saying or feeling. I, at the time, just took the approach of being like, “I didn’t say that. Here’s what is real about our relationship.” I do not know, now I’m not sure if that was the best way to do it.”
Discussion

In the project described here, our goal was to explore provider views on service ideals and values vis-à-vis clients with psychosis, the current state of services and perceived macro- and microlevel constraints and barriers to quality improvement. Providers within our sample consistently emphasized the foundational importance of the therapeutic relationship rather than mastery of specific techniques, and the value of engaging with the subjective meaning of clients’ beliefs and experiences on clients’ own terms. Participants described multiple macrolevel factors that they felt worked against these ideals, including the broader marginalization of serious mental illness, detrimental billing procedures, provider turnover and lack of preparation, and the increasing mechanization of mental health services. Finally, participants noted two key interpersonal challenges: balancing the basic needs of clients with “deeper” clinical work, and navigating boundary issues stemming from the diverse roles they frequently occupy, particularly in the context of community-based, multidisciplinary service models.

Perhaps the most important upshot of this work is its reminder of the need for research and programmatic work focused on strengthening agency’s and providers’ capacity to work with psychosis across settings, roles, and program areas rather than through the narrower implementation of specific interventions (such as a cognitive–behavioral therapy for psychosis group or brief trauma focused intervention). As these analyses—and important recent ethnographic projects (Brodwin, 2013; Myers, 2015)—suggest, providers in the public mental health system typically interact with clients in multiple, multifaceted ways, struggling to meet often overwhelming human needs (and degrees of socioeconomic disadvantage) and navigate complex moral and ethical challenges, all under the auspices of a heavily bureaucratised and underresourced service system. The majority of public health workers do not have any kind of license or clinical degree (Hoge et al., 2009; Weil, 2015). Arguably, discrete interventions better align with the larger field of biomedical research and clinical trial funding mechanisms, but beg the question of whether other kinds of systemic workforce training and support initiatives or organizational interventions might more efficiently improve the quality of services (and experiences of clients within them). As Kidd, Mckenzie, and Virdee, 2014 highlight, in regards to inpatient care, the importance of general training (e.g., in recovery oriented care) is critical in mental health reform regardless of the setting, and the common factors literature may have much to contribute.

Our analyses also reinforce what we see as a growing push to move from a science of implementation (understood as the implementation of relatively rigid practices) to one of adaptation, in which practices are modified or even fundamentally reshaped in response to such local factors as “client emergent issues,” provider knowledge and capacity, available resources or resource constraints, and organizational characteristics (Aarons et al., 2012; cf. Chambers & Norton, 2016; Greenhalgh, Howick, & Maskrey, 2014). Under this kind of model, key issues brought forward by our participants, such as the perceived misfit between rotating team-based services and more traditional therapy, could be used to make potentially substantial model changes, rather than feeling stuck, as one of our participants put it, with “the ways the models don’t come together.”

In our sample, clinicians’ stated investment in “deeper” therapeutic work, including what several participants described as a “relational” way of engaging with the content and experience of psychosis, is also worth noting. The vast majority of our sample reported virtually no formal preparation relevant to such work, including those with master’s and doctoral level training backgrounds. Given the stakes of improving outcomes among clients diagnosed with psychosis—arguably the single psychiatric disability subgroup at greatest risk of long-term unemployment, homelessness, premature morbidity, and program disengagement (Lally et al., 2017)—there is a pressing need to better support the front-line staff who provide the majority of their services, and to do so in a way that both emphasizes healing and collaborative exploration (Corstens, Longden, McCarthy-Jones, Waddingham, & Thomas, 2014; Thomas et al., 2014) and effectively address challenges such as the complex interpersonal boundaries and the juggling of clinical and more basic needs.

Limitations, Conclusions, and Future Directions

Important limitations of the current article include that the sample was drawn from a single agency in a single state, and one whose service mandate limited eligibility to clients with established and severe psychiatric disabilities. Throughout the focus groups, clinicians described or referenced the presence of “less skilled” providers at their agency in spite of explicit attempts to diversify the sample based on experience, geographical area, and relative skill or talent, participant comments, and level of knowledge arguably suggested that we nevertheless ultimately oversampled skilled providers and/or those with a stronger commitment to and interest in psychosis. It is also worth underscoring that different states and different agencies handle the care of individuals with serious mental illness (SMI) in a variety of ways, with some providing far more dedicated office therapy than the partner agency for this project.

Finally, although our study focused on psychosis, many of the participant’s points were clearly broader in scope and applicable to clients in general, not just those with psychotic disorders. Psychosis nevertheless raises particular questions about collective meaning and cultural integration that arguably merit additional scrutiny in the context of research, underscored in our analyses by clinicians’ discussion of the particular challenges negotiating delusions and hallucinations in which they had themselves become incorporated, and in meaning-focused clinical work. While a growing chorus of publications in the United Kingdom, Australia, and Europe have called for, or pressed on with, such themes (Beavan & Read, 2010; Corstens et al., 2014; Thomas et al., 2014), “meaning-centered” practice remains seriously underdeveloped in the United States (Dillon & Hornstein, 2013).

In summary, we see the primary contribution of our project as its attention to the ways in which constraints and contingencies at macro and microlevels shape clinicians’ work with clients experiencing psychosis as well as to issues implicit in the broader quality of care within a given program or agency rather than specific components or
interventions. In spite of the pressing need to improve outcomes for public sector clients with psychosis, providers in our sample reported a pronounced lack of prior training and continuing education in psychosis-specific approaches or best practices. We call for greater attention to the challenges that front-line providers face in serving individuals with psychosis, providers’ perspectives on best practices, and significantly increased investment in strengthening workforce and organizational capacity.

Keywords: psychosis; schizophrenia; public mental health; practice-based evidence; clinical intervention

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