

# Residents' Journal

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The concept of advocacy for psychiatry, particularly as it relates to public policy and public information, can be off-putting to some, if not frightening, as it seems to require highly sophisticated skills in mass media communication and Congressional lobbying. Such fears are unnecessary. Throughout history, physicians have advocated for their patients' health, whether through public health initiatives such as improving the water supply and sewage sanitation, or through promoting public policy that supports patient care. As physicians, we may address patients' needs one-by-one as we care for patients in our offices, but we also have concern for the health of a larger patient (or prospective patient) population—the public. Physicians, understanding that knowledge is power, have long worked to provide education to the public and policymakers on the origin, natural history, and treatment of disease, as well as ways to promote health and well-being. Thus, advocacy involves speaking for patients, both as individuals and as communities, in many settings and is a part of our responsibility as physicians.

When we speak about advocacy for psychiatry, we tend to address the remnants of stigma and discrimination—attitudes that influence public policy as well as impede access to care. I see public and professional education as a major basis of advocacy. While we may focus on the national aspects of advocacy (e.g., lobbying before Congress, speaking on radio or television programs, or preparing editorials for newspapers such as the *New York Times*), we also need to increase our efforts to educate and influence in more prosaic, community settings.

Residents and more experienced psychiatrists alike often view advocacy as something difficult and different, not recognizing that advocacy can be a simple part of everyday activities and is as important locally as it is nationally. Since advocacy begins with information, residents can gain experience through presentations and consultations to various community organizations and agencies, especially schools (including Parent Teacher Associations) and houses of worship. Helping the public learn about psychiatric disorders also leads to the negation of myths and misconceptions, particularly those about diagnosis (e.g., so-called "warning signs"), causes of psychiatric disorders (e.g., mental illness is not a weakness of will or morality), and treatments, including kinds of treatment, cost, and effectiveness. Residency directors, supervisors, and other faculty can assist residents in preparing talks for these settings, and APA offers additional resources

through its member web site ([www.psych.org](http://www.psych.org)) and its public information web site ([www.healthyminds.org](http://www.healthyminds.org)). Linking with patient-centered advocacy organizations such as the National Alliance on Mental Illness (NAMI) can provide a patient's perspective, educating psychiatrists as well as the public. Advocacy also takes place in the consultation-liaison setting, as residents can provide information to referring physicians and health professionals about psychiatric disorders. This interplay between psychiatric and other medical professionals helps to increase understanding and modifies outdated and incorrect views and misconceptions.

The next step may be to work with local and state legislators. Informing legislators may seem daunting, but it is important to recognize that as residents, you have considerable knowledge and experience that is of value to legislators and their staff. Again, it is useful to work in partnership with faculty, and APA can provide printed materials on topics such as the impact of illness and cost of care, in addition to fact sheets on clinical topics (for more information contact Nancy Delanoche, Associate Director of the Department of Education, [[ndelanoche@psych.org](mailto:ndelanoche@psych.org)], or Eugene Cassel, Director of the Division of Advocacy [[ecassel@psych.org](mailto:ecassel@psych.org)]).

Of course, we also need to work with the business community, which is only now beginning to realize the huge financial impact of untreated mental illness and the economic benefit that good care provides. Again the APA, which regularly meets with business leaders and conducts studies on the cost of mental health care, is a tremendous resource which can provide impetus for work in your community (for more information contact Clare Miller, Director of the Partnership for Workplace Mental Health [[cmiller@psych.org](mailto:cmiller@psych.org)]).

APA also provides informational materials and actions through its web sites, as well as through the efforts of the Office of Communications and Public Affairs and the Department of Government Relations (see the Members' Corner online for more information). News briefs, action alerts, and Listservs contain up-to-date information about current legislative initiatives that apply to our patients and instructions regarding contacting legislators. Residents interested in pursuing this topic further can find formal learning opportunities at APA meetings, especially the Institute on Psychiatric Services (New Orleans, October 11–14, 2007), and through practical sessions on aspects of



advocacy. Upon request, staff from the Division of Advocacy will visit local psychiatric societies (district branches and state associations) and academic psychiatry departments to conduct more specific hands-on training sessions, with a focus on how to effectively craft and communicate your message (contact Eugene Cassel for more information). APA officers and other leadership (including this President) are also delighted to visit psychiatry departments and present at grand rounds, as well as meet with residents to discuss practical aspects of advocacy. And of course, residents can attend APA's Advocacy Day, which focuses on national issues, providing connections and networking opportunities in addition to specific skill development.

Your local psychiatric society welcomes residents and early career psychiatrists to assist in its advocacy efforts, and in addition will often provide mentoring

partnerships in which a more seasoned clinician is partnered with a resident, as well as connecting volunteers with local chapters of advocacy organizations such as NAMI or Mental Health America.

For me, the most important advocacy issue facing us as a profession is nondiscriminatory access to care. This means treating psychiatric disorders as any other disorder, without special "permission" to seek care, higher co-payments or deductibles, or limits on length of treatment. Inappropriate management of care (or really, of cost) is also a major issue impacting patients and general public health. Other important issues include confidentiality and scope of practice (i.e., ensuring that those providing care are properly trained to do so). This is a good time to be an advocate, for more visible partnerships with advocacy organizations and celebrity disclosures have helped diminish the stigma of mental illness, business leaders are increasingly understanding of

the importance of a healthy work force, and recent achievements in science have not only promoted understanding, but also led to better treatments. There is greater public understanding of mental health issues, and there is increasing awareness of the impact of depression and posttraumatic stress disorder on returning military, as well as the impact upon their children and families. The military and the public have joined together to support veterans' access to good mental health care without the stigma of appearing "weak." Simply put, our message is this: mental health is as important as physical health. Psychiatric disorders are real disorders. They can be diagnosed accurately, and treated successfully and in a cost-effective manner.

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## Advocacy for People Who Are Homeless: The Many Ways We Can Help

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What is associated with treating people who are homeless? This group, burdened with poverty, stigma, and unique mental and physical health needs, is too often met with a disheartened reaction. When I first began working with this population, I felt both inspired and disheartened by the intensity with which I wondered, "Can we possibly help?" I have come to believe we indeed can.

Certainly, the needs are tremendous. Homeless adults have, on average, eight to nine chronic medical illnesses over the course of their lifetime and a life expectancy of only 45 years of age (1). Many homeless adults (33%–50%) are affected by serious mental illness and up to 63% have substance use disorders (2). The complexity of their needs, the lack of available services, and the population's tendency towards isolation and disaffiliation may elicit feelings of discouragement in caregivers.

With individual patients, we can begin by listening and understanding their lives. We may believe that psychiatric treatment comes first; however, successful engagement begins by understanding the patient's priorities. For many homeless adults, health care is less urgent than survival needs such as blankets, clean socks, food, or showers. Transportation, employment, and public assistance are other common priorities. Attending to the patient's concerns first relieves suffering and builds trust.

The patient's chief concerns are a logical starting point to discuss treatment (3). Practical constraints

must be considered when creating a treatment plan. Once-daily dosing helps those with no available storage for medications. People who are homeless, especially those with a mental illness, are at increased risk for assault (4); medications with a sedating effect may further increase this risk. Limited access to water and private restrooms may make side effects such as polyuria or diarrhea especially problematic. Furthermore, it may be necessary to provide transportation for the patient, or arrange for lab work within walking distance or on a public transportation route.

As mental health care providers, we should become knowledgeable about the resources in our community. Is there a warm place to go in the winter? Is there a place to get clothing or food? Who can assist in finding housing? Which substance abuse centers will accept public insurance? While some of these questions might seem outside of the realm of our usual practice, they are important components of recovery.

On a more global scale, we can increase awareness of legislation affecting people who are homeless, such as legislation on housing subsidies, public insurance, and disability benefits. We can provide financial or logistical support to organizations lobbying in support of our patients. We can meet with local, state, or federal representatives, who often welcome the perspective of a physician who cares for the constituents. Organizations (including

APA) provide services alerting members to contact legislators about key votes.

Finally, we can maintain hope. I know many patients who believe their situation is inescapable. Some lose faith that they will ever get needed services or feel better. It is understandable that we sometimes join our patients in these fears, but I believe we serve our patients best when we use what resources we have to achieve as much improvement as possible, while continuing to imagine and pursue better solutions.

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# Advocacy for Parents With Mental Illness and Their Families

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Women living with mental illness do become pregnant and raise children (1). Adults with psychiatric disorders across major diagnostic groups are as likely, if not more, to be parents as those not meeting criteria for psychiatric disorders (2). The majority of women (65%–67%) with a major mental illness, including severe and persistent mental illness, are mothers (1, 3). Motherhood is a normative life experience for most women, including those with mental illness, and can create meaning in the lives of women living with mental illness and serve as a motivating and organizing factor that can sustain participation in treatment (3). Most mothers living with mental illness and caring for their children describe motherhood as rewarding and central to their lives (4).

Families living with parental mental illness face multiple vulnerabilities. One primary concern is family separation and disruption resulting from psychiatric hospitalization and/or child welfare involvement. Significant numbers of mothers with mental illness lose custody of their children, at rates as high as 60%–70%, and this loss can have a profound lifelong effect. Almost half the children of parents with mental illness have an emotional or behavioral problem (1, 2). These families also have high rates of co-occurring poverty, substance abuse, and homelessness, which have serious implications

for safe parenting (3). Services and interventions designed to address safe parenting are more often found within the child sector, are predominantly deficit-based, and are made available only when children are judged to be in high risk environments or at risk for out-of-home placement. Preventive, strength-based interventions are rare (2), and there is a tendency for practical help to be withdrawn as soon as the immediate crisis has been resolved (4).

I have learned firsthand about the challenges facing parents with mental illness while leading a parenting group participating in the Family Options for Parents and Children Study. This study provides parents who have serious mental illness a family coach and practical support in order to build on their strengths and better focus on resilience and rehabilitation. Most of the mothers in my group have children with significant mental health challenges of their own, and they struggle to navigate through complicated systems and multiple agencies to meet not only their own needs, but also those of their children. They face the general challenges of parenting as well as the unique challenges of mental illness. Adherence to treatment and appointments is compromised by attempts to prioritize. For example, taking medications with a sedating effect at bedtime makes it harder for mothers to send their children off to school in the morning. It is also difficult to

maintain scheduled appointments when adequate child care is not readily available, and most providers will not accommodate a woman arriving for her appointment accompanied by children. As psychiatrists, we often do not ask about parenting, which can be a central motivator and major stressor. We should not miss this opportunity to understand the importance of parenting to our patients and intervene in order to help. Like most parents, parents with mental illness simply aspire to be the best parents they can be for their children.

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