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ORIGINAL PAPER

Cultural Issues in Psychiatric Administration and Leadership

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Abstract This paper addresses cultural issues in psychiatric administration and leadership through two issues: (1) the changing culture of psychiatric practice based on new clinician performance metrics and (2) the culture of psychiatric administration and leadership in light of organizational cultural competence. Regarding the first issue, some observers have discussed the challenges of creating novel practice environments that balance business values of efficient performance with fiduciary values of treatment competence. This paper expands upon this discussion, demonstrating that some metrics from the Centers for Medicare & Medicaid Services, the nation's largest funder of postgraduate medical training, may penalize clinicians for patient medication behaviors that are unrelated to clinician performance. A focus on pharmacotherapy over psychotherapy in these metrics has unclear consequences for the future of psychiatric training. Regarding the second issue, studies of psychiatric administration and leadership reveal a disproportionate influence of older men in positions of power despite efforts to recruit women, minorities, and immigrants who increasingly constitute the psychiatric workforce. Organizational cultural competence initiatives can diversify institutional cultures so that psychiatric leaders better reflect the populations they serve. In both cases, psychiatric administrators and leaders play critical roles in ensuring that their organizations respond to social challenges.

Keywords Cultural psychiatry · Cultural competence · Psychiatric administration · Leadership · Organizational culture

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The papers in this special issue contribute to our knowledge of psychiatric administration and leadership. This paper situates these papers within the discipline of cultural psychiatry to cull central themes and offer future directions. The focus is on two issues: (1) the changing culture of psychiatry in light of emerging efficiencies defined through clinician performance metrics and (2) the culture of psychiatric administration and leadership from the perspective of organizational cultural competence.

Cultural psychiatry offers a background to trace shifting conceptions regarding culture *in* psychiatry and the culture *of* psychiatry. A persistent research concern in cultural psychiatry has been the analysis of psychiatric knowledge, practices, and institutions to demonstrate their reflection of cultural values within society at large [1]. Cultural psychiatrists over the past 40 years have developed this critical self-awareness largely through dialogue with medical anthropologists who examine culture as their scholarly unit of analysis [2–4]. It is now widely accepted among cultural psychiatrists and medical anthropologists that medicine in general, and psychiatry in particular, cannot be separated from the social contexts of practice since cultural values dictate scientific priorities [5, 6] and political economy dictates billable diagnoses and rules for reimbursement throughout medicine [7–9]. For example, ethnographies of leadership in institutions such as residency programs [10] point to the increasing influence of corporate values emphasizing cost-efficiency that can occasionally conflict with Hippocratic values of patient care [11]. Corporate values can transform clinical work when population-based algorithmic pathways for treatment replace person-centered care based on a subjective understanding of the illness experience [12]. This is not to suggest that cost containment or guideline-based care are undesirable, but that such social forces remake the knowledge, practice, and institutions of mental health, meriting closer analysis.

For example, the theme of corporate values influencing psychiatric organizations appears in several papers in this issue. Saeed et al. discuss the challenges for psychiatric leaders and administrators in cultivating practice environments that must balance the technical competence of psychiatry with acceptable performance-based outcomes [13]. Merlino et al. also detail the frustrations of financing high-quality clinical practice based on performance-based outcomes in under-resourced environments confronted with decreased government expenditures and greater managed-care restrictions [14]. Finally, Moffic et al. review the rise of managed-care organizations in the 1980s that have changed psychiatric practices such as reducing inpatient hospitalizations, decreasing psychotherapy reimbursements, and increasing 15-min medication appointments [15]. In separate ways, these papers all argue for a greater role of psychiatric administrators and leaders in constructing new feasible, acceptable, and useful practice paradigms within clear financial constraints.

These valuable points notwithstanding, theories in cultural psychiatry can help us analyze certain assumptions shared by these authors and by the developers of performance-based outcomes. Many performance-based outcomes prioritize corporate interests, but the extent to which they align with patient or clinician interests is unclear. This is illustrated by a review of mental health performance-based outcomes mandated by the Centers for Medicare & Medicaid Services (CMS) for 2014. CMS measures are a useful starting point for analysis since Medicare has been the primary supporter of residency training programs in all medical specialties, funding approximately 100,000 positions in teaching hospitals [16]. CMS's 2014 *Physician Quality Reporting System* (*PQRS*) *Measures List* [17] includes the following among its performance-based measures for mental health:

- Major depressive disorder medication management is defined as "the percentage of patients 18 years of age and older who were diagnosed with major depression, and who remained on antidepressant medication treatment" for 84 days as acute treatment and 180 days as chronic treatment.
- Attention deficit-hyperactivity disorder medication management is defined as the "percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended."
- Depression remission at 12 months is defined as "adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at 12 months defined as PHQ-9 score <5".

The use of performance-based measures may improve clinical care as clinicians become financially motivated to implement assessment tools for screening and prevention. Nonetheless, the above measures suggest that CMS may occasionally evaluate clinicians according to factors more in the control of patients. The first two measures define clinician performance outcomes by patient adherence to medications. However, patients may discontinue medications due to adverse reactions or unsatisfactory interactions with clinicians [18]. In addition, many patients may not culturally perceive the need for medication beyond the acute episode of depression, may fear long-term physical and psychological dependence on medication, and may not return to treatment if they believe that clinicians do not understand their treatment preferences [19]. Stigma against mental illness and socioeconomic barriers can also affect treatment continuation in children and adolescents with ADHD [20]. An evaluation of clinician performance based on patient medication behaviors does not directly account for clinician practice and can even penalize clinicians who adhere to the strictest treatment guidelines.

Performance-based outcomes for clinicians that are centered on patient medication adherence also ignore clinical evidence that there is not a direct relationship between clinician medication prescription and the successful treatment of mental disorders. Clinician adherence to and competence with cognitive-behavioral therapy (CBT) is not included as a performance-based measure even though the World Health Organization recommends CBT along with other psychotherapies as first-line treatments for mild to moderate depression [21]. Therefore, performance-based outcomes centered on patient medication adherence may ignore the worldwide evidence base demonstrating the successful treatment of depression through psychotherapy. Depression remission also has no clear relationship to medication adherence. Depression remission can occur spontaneously in as many as 10–15 % of those with major depressive disorder who do not receive medication [22], and 30 % of people with depression do not respond to an antidepressant even when it is prescribed at the recommended dose [23]. These CMS performance-based outcomes indicate a cultural valorization of psychiatrists who provide pharmacotherapy over psychotherapy with unclear implications for clinical practice and future physician training. In response, psychiatric residency programs may devote more time to pharmacotherapy rather than psychotherapy given CMS's financial clout. Psychologists and mental health nurses may also lobby for more prescribing autonomy if they perceive that CMS disvalues their services.

Psychiatric administrators and leaders in healthcare organizations are well poised to articulate discrepancies in performance-based outcomes based on clinical roles and responsibilities given their interactions with a wide variety of stakeholders such as patients, clinicians, payers, and regulators. An important contribution of medical anthropology to

health services research has been the insight that patients, clinicians, administrators, and other stakeholders think and behave differently based on their differing social positions [24]. Psychiatric administrators and leaders can advocate for improved measures that simultaneously account for clinician performance and patient treatment preferences within evidence-based guidelines by identifying areas of common interest across stakeholders. For example, definitions of medication management for mental disorders should not only examine whether clinicians prescribed a medication; they should also monitor whether patients fill these prescriptions to avoid penalizing clinicians for patient behaviors. CMS maintains patient claims data for Medicare and Medicaid, allowing program evaluators to check billable diagnoses and medication prescriptions for each patient. Psychiatric administrators and leaders can pursue such advocacy through involvement in state and national psychiatric organizations such as the American Psychiatric Association, Group for the Advancement of Psychiatry (GAP), and the American College of Psychiatrists whose members interface with CMS and other payers. CMS has announced that its measures are subject to change based on input from organizations on how best to assess quality. Proactive engagement on behalf of patients and clinicians can assist psychiatric administrators and leaders with cultivating effective and efficient practice environments despite limited resources.

The second issue taken up in these papers is the culture of psychiatric administration and leadership at the institutional level. Petit and Saeed [25] present the results of a survey conducted by GAP's Committee on Psychiatric Administration and Leadership conducted a survey revealing a disproportionate influence of older men in administrative and leadership positions despite attempts to recruit more women [25]. Institutional policies, evaluation activities, resource allocation, and institutional language have been identified as observable elements (and therefore, amenable to study) that exhibit the organizational culture of medical institutions [26]. Without enrolling underserved racial and ethnic minorities or international medical graduates who increasingly constitute the basic workforce into leadership and administrative positions, psychiatric organizations risk losing touch with broader trends in labor diversification throughout society [27, 28]. Even though the cultural competence movement has spawned hundreds of initiatives and interventions to improve the care for historically disadvantaged racial and ethnic minorities [29], few reports exist on the organizational cultural competence of psychiatric institutions such as medical schools, hospitals, and provider networks [30]. Organizational cultural competence in psychiatric institutions has been studied less in the United States than in other countries. The few empirical studies available include a report from researchers in England who have found that plans and procedures to promote cultural competence tend not to be communicated to frontline staff in one London Hospital [31] and another report from researchers in Canada who found that a community mental health center only fully met 28 of 53 standards for cultural competence [32]. Even though academic psychiatrists have long attempted to implement cultural competence initiatives in medical schools [33], few initiatives have been subject to critical evaluation.

Here again, psychiatric administrators and leaders can play critical roles in diversifying organizations. Novel initiatives and interventions may experience limited adoption and sustainability without the dedication of key stakeholders and decision makers such as administrators and leaders who act as role models in organizations [34]. Diversity initiatives for women, racial and ethnic minorities, sexual and gender minorities, veterans, and other populations that have been historically disenfranchised may have a greater chance of success if psychiatric administrators and leaders act as such role models. This can occur at the level of institutional policies, evaluation activities, resource allocation, and explicit language to reflect organizational cultural competence. Published studies can help to

disseminate best practices, lessons learned, and areas for improvement that can be debated and acted upon by administrators and leaders in other organizations. Psychiatric administrators and leaders who embrace these pivotal responsibilities will not just be changing the culture of psychiatry, but demonstrating a commitment to social equity for the populations that they serve.

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Conflict of interest The authors declare that they have no conflict of interest.

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