



PSYCHIATRIC LEADERSHIP IN CRISIS SYSTEMS:

The Role of the Crisis Services Medical Director

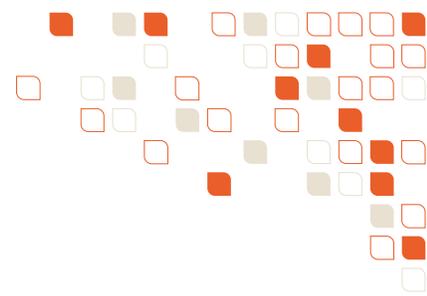
This guidance on Psychiatric Leadership in Crisis Systems: The Role of the Crisis Services Medical Director was developed by the Crisis Services Subcommittee of the Medical Director Institute of the National Council for Mental Wellbeing. This brief guidance expands on the recommendations of the recently released report, [Roadmap to the Ideal Crisis System](#) and provides additional guidance for how crisis system medical directors can be most effective in their roles.

INTRODUCTION

Just as medical emergency services are expected to have physician leadership, clinical and medical (psychiatric) leadership is a necessary component of an ideal mental health and substance use crisis system (please see [Roadmap to the Ideal Crisis System](#), pages 125-126). A crisis services medical director (CSMD), usually working in collaboration with a crisis services clinical director (CSCD) who is not a psychiatric care provider, can be uniquely positioned to provide direction and oversight of administrative, operational, educational and clinical activities related to patient care, including quality improvement, coordination with medical services and other key functions listed in Table 2. Any agency providing mental health and substance use crisis services would benefit from having a designated CSMD with a substantive role in the leadership team. The CSCD and CSMD should be positioned to work collaboratively to provide clinical and administrative leadership to the entire crisis continuum; leadership provided by a CSMD should be built in at an early stage of planning.

Rationale for investing in psychiatric leadership in a crisis system.

As crisis systems develop and expand across the U.S., mental health and substance use treatment leaders are encountering an unprecedented influx of interest and funding to develop high quality services for some of the most clinically complex and psychosocially challenging encounters. Populations accessing crisis services typically experience a range of psychiatric symptoms with high acuity, often combined with medical comorbidities, all of which require thorough psychiatric evaluation, medical screening and triage to promote least restrictive interventions. In addition, multiple systems are routinely involved in these interactions, including mental health and substance use treatment, emergency medical services, law enforcement, 911/emergency dispatch, social services, educational institutions and others. With such complexity comes significant risks for negative outcomes. As such, the role of the CSMD within the leadership team is essential in systems seeking to deliver high-quality, safe and person-centered care, which is equivalent to the standard of care within emergency medical services. We should build upon that standard of care as a foundation.



The Role of the Crisis Services Medical Director

The goal of medical leadership within a crisis system is to help ensure that processes and clinical activities undertaken by a crisis system and its personnel meet the standard of care and are appropriate and effective in resolving or ameliorating crises. Also, given the many complexities in crisis systems, including the relationships between mental health and substance use treatment services and partnered agencies (e.g., emergency medical services, law enforcement), the influence of a CSMD will depend upon collaboration with other clinicians and non-clinical personnel. To be successful, CSMDs need to demonstrate a keen ability to navigate various workplace cultures and sensitive multi-stakeholder dynamics that are ubiquitous in crisis systems. To be most effective at leveraging their skills and creating a positive influence, CSMDs should exemplify the qualities described in Table 1.

Table 1. Five Important Clinical Standards and Quality for a Medical Leader (and One to Avoid) (adapted from Packard, Becker’s Hospital Report, 2015)

POSITIVE					AVOID
					
1. Listening	2. Vision	3. Integrity	4. Empathy	5. Optimism	“Authoritarian” Style

Table 2 describes the actions, aptitudes and experience needed for a CSMD to effectively promote medical and psychiatric actions in a crisis system. Additional formal and informal training in strategy, team functioning, finance and operational management may enhance the capabilities of a CSMD. The following grid contains activities beyond those typically ascribed to a medical director. These action and outcomes-oriented, strategic medical leader qualities represent the evolving expectations and proficiencies of medical leaders. Consequently, some of these elements may be aspirational for even the most qualified medical directors.



Table 2. CSMD Functions and Capabilities



QUALITY

- Active participant in continuous quality improvement and data analytics, able to translate clinical insights to actionable improvements.
- Establishes standards for crisis work based on industry/national quality standards.
- Meaningfully participates in multidisciplinary team processes to ensure quality outcomes and standards of care are met.
- Meaningfully participates in quality assurance and improvement processes directed at key outcomes.
- Key member of risk and sentinel event reviews and uses data to improve clinical services.



CLINICAL LEADERSHIP

- Stakeholder team resource on crisis evidence-based practices and integrated care.
- Able to be a care model innovator in designing the crisis services continuum while considering unique regional needs, resources, value-based design and delivery tactics.
- Creates and supports care delivery models that are recovery-oriented, customer-centered, culturally competent, inclusive and welcoming of diversity.



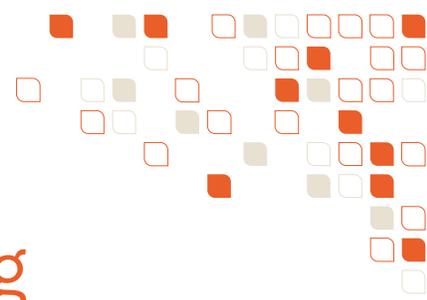
SYSTEM CHANGE AGENT

- Able to engage all stakeholders including community thought leaders, providers, health systems, participants, families, peers, payers, regulators and legislators.
- Able to identify and aggressively pursue potential funding mechanisms.
- Skilled in financial concepts and value-based negotiations.
- Experienced in system change management.
- Able to identify crisis continuum gaps from both the behavioral and the physical health system’s perspective.



COMMUNICATOR

- Able to foster a collaborative environment, alignment and psychological safety within the stakeholder team and trust with the community at-large.
- Communicates with authority and humility.
- Is intellectually honest.
- Keen listening skills and engages others for best ideas.
- Able to communicate the common vision to payers, legislators and community partners to assist with commitment and generation of sustainable funding streams.
- Models empathetic, person-centered leadership and team-work style.
- Acts as the medical community provider liaison, starting with needs assessment and design, going through implementation and continuing after the crisis continuum has been established.
- Able to foster a collaborative environment, alignment and psychological safety within the stakeholder team and trust with the community at-large.
- Keen listening skills and engages others for best ideas.



Practical Strategies for Creating a CSMD Position

Being an effective CSMD requires adequate time commitment (protected time) for participation and responsibilities at the senior strategic, quality and administrative levels. This allocation should be distinct and apart from other specific accountabilities such as quality improvement and clinical service delivery. A meaningful level of authority in the organizational hierarchy is needed for optimal medical leadership impact. Given the likelihood that the credentials and time commitment of a CSMD will vary depending on the size and organization of the crisis system, the following strategies may facilitate successful creation of a CSMD position:

- Ensure adequate (protected) strategic planning and administrative oversight time beyond quality improvement and clinical service delivery built into the cost structure for the CSMD role. Adding CSMD responsibilities to an existing organizational medical director role (e.g., for psychiatric emergency services) is not likely an optimal construct.
- Multiple new funding sources for crisis services are becoming available. It would be reasonable to earmark a portion of those funds to support the crisis services medical director position.
- It is desirable, when possible, for medical leadership to model high quality clinical care through direct clinical service. Examples of such activities include a combination of onsite (or telehealth/telemedicine) direct medical service, including crisis evaluation and consultation, post-crisis care, short-term medication management and on-call availability.
- In some systems, it will not be possible to combine the medical service delivery, medical/clinical case and protocol oversight and quality improvement functions in one individual or role. In those systems, dedicated medical leadership is crucial.
- Smaller systems with fewer resources may find it helpful to pool resources and create a regional crisis system that leverages a CSMD across a larger catchment area.

Conclusion

Never before have crisis systems expanded so rapidly, with significant increases in funding, national recognition and coordination in anticipation of 988 and political urgency to create mental health specialist responses as alternatives to law enforcement. Inclusion of a qualified CSMD is an important step toward developing an ideal crisis system.