COMMUNITY PSYCHIATRY:

PROBLEMS AND POSSIBILITIES

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Community Psychiatry: Problems and Possibilities

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CMHCs AND PSYCHIATRISTS:

A NECESSARILY POLEMICAL REVIEW

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Abstract

The author initially presents an historical perspective of the community mental health movement. The central problem of conflict regarding the CMHC psychiatrist's role is explored. Additional complaints by psychiatrists about CMHCs are described. The degree to which these problems have resulted in an exodus of psychiatrists from CMHCs is addressed. Efforts to redress this exodus must begin by appropriately defining the CMHC psychiatrist's role. Other strategies aimed at enhancing the recruitment and retention of CMHC psychiatrists are suggested. Finally, the author, elaborating on the work of Langsley and Barter, outlines the collaborative responsibilities of centers, psychiatric training programs, the psychiatric profession, government, and the CMHC psychiatrists, themselves, if the problems discussed in the paper are to be fruitfully resolved.

An Historical Perspective

In 1963, John F. Kennedy envisioned that the community mental health center revolution in psychiatric care would involve "physicians . . . treat(ing) patients in a mental health facility served by an auxiliary professional staff."[1,2] This was in keeping with the recommendations of the Joint Commission on Mental Illness and Health in 1961 which sought to preserve most of the traditional exclusivity of the psychiatric role. While the commission recommended that well qualified nonmedical clinicians could do short-term therapy, responsibility for diagnosis, case disposition, and all other types of therapy were to remain with psychiatrists.[3,4]

Freedman summarizes what then occurred on a macro level:

> "Psychiatrists were initially mandated by regulations to be in charge of the community mental health centers, but subsequent regulations shifted the rules and subsequent developments found few psychiatrists within CMHCs (and fewer within NIMH and its various components). Both the field and Congress were repeatedly told that the communities demanded these CMHC arrangements (a prophecy which, it was hoped, would be replaced by fact). The state hospitals and academia were both coaxed and fed — and hence distracted; the private practitioner was unthreatened. There grew, finally — with a minimum of professionalized direction — a disparate array of services . . . the 120-year agenda that seeks above all a federal commitment to the mentally ill is surely to be respected, but the price in minimal technical and professional accountability in not linking the ill to health and welfare systems is surely yet to be assessed."[5]

Tourlentes summarizes what ensued on a micro level:

> "The original idea, of course, was to bring other mental health professionals under the umbrella of psychiatry in a coordinated effort which would have the effect of amplifying psychiatric services for larger numbers of people. It was generally agreed at the outset that these were to be vertically organized and distinctively hierarchical inter-relationships, and not indiscriminately homogenized lateral or egalitarian ones. However, it was not long before catch words like 'role-blurring' and slogans like 'freedom of choice' were introduced into the picture. As tolerant, understanding, and fair-minded mother-father figures, we were inclined to say little in opposition to this line of thinking, and soon it was taken for granted that there was consensus on the whole proposition. Similarities were all that mattered, differences were to be ignored."[6]

Ironically, the CMHC movement, conceived largely by psychiatrists to improve standards of mental health care nationally, has evolved to date in such a way that psychiatrists are being utilized less and less while other mental health professionals are used more and more.[7] Certainly one reason why psychiatrists are becoming a vanishing resource in CMHCs is due to the centers' major reduction in medical involvement. As CMHCs moved away from their community hospital bases and became co-opted by community governance boards, they greatly weakened their status as health care institutions.[2] Many CMHCs, acting on the premise that the need was so great that the risks were warranted, established themselves as free-standing agencies without effective non-psychiatric medical support (Kuehn JL: "The Physician and the Community Mental Health Center Revisited." Unpublished paper, 1983). Another reason why psychiatrists are a diminishing resource in CMHCs, according to Tourlentes, is that, "Fiscal management experts now in control have done a very

good job of selectively embracing the rhetoric of community mental health theory without accepting basic clinical responsibilities which are necessary to make it work."[6] If a manager can hire three or four other mental health professionals for the price of one psychiatrist, and yet get reimbursed by third party payers (who often fallaciously presume that there is adequate psychiatric oversight) at equal rates for both, it is clear why such a manager would be tempted to hire as many other professionals (and even non-professionals!) and as few psychiatrists as possible. However, sacrificing quality for the sake of short term financial gain may well ultimately be more costly for the entire system. Not having adequate numbers of competent psychiatrists in CMHCs to provide the patient with a stable biological foundation, without which all other treatment efforts are for nought, is likely to result in costly local or even state hospitalization.

Coinciding with community mental health's becoming less medically oriented have been advances in psychobiological research, along with psychiatry's conscious effort to return to its medical roots.[8] While CMHCs have been becoming less medically oriented, psychiatry has been becoming more so, thus exacerbating the split between the two. According to Arce and Vergare, this remedicalization of psychiatry may have aggravated existing role conflicts for community psychiatrists and further eroded the diminishing psychiatric manpower base in community mental health.[9]

The reduction in both numbers and influence of psychiatrists in CMHCs has been termed "deprofessionalization"[10] and "demedicalization."[11] The shift from psychological and biological systems of treatment to a social-service model was, as Mollica observes, promoted by policy makers partly because they believed that practitioners of the medical approach were insensitive to lower-class patients, poor interdisciplinary team players, and overpriced.[11] Additional factors contributing to this "demedicalization" have been a lack of clear purpose for CMHCs, conflicts over authority, and reductions in funds. When funding cuts, endorsed by non-psychiatric government officials, are combined with an anti-professional community bias, Fink and Weinstein note that centers often simplistically conclude that money can best be saved by eliminating the higher priced personnel and substituting less expensive mental health workers.[10] Unfortunately, according to Arce and Vergare, the result of this phenomenon is that CMHC patients are receiving increasingly less sophisticated psychiatric care.[9] Kuehn asks whether such incomplete evaluation and the resultant risk of inappropriate treatment are really better than no treatment at all (previously referenced unpublished paper).

There is growing concern over the potentially negative impact of such deprofessionalization on the quality of patient care, even among non-psychiatrists. Harold Boyts, M.S.W., Past-President of the National Council of Community Mental Health Centers, is concerned that CMHCs are at risk for going the way of many state hospitals (personal communication). Fink and Weinstein, too, are concerned that the emerging CMHC climate of deprofessionalization in both administration and patient care seems to be recapitulating the situation that developed in the state hospital system earlier in this century, when the quality of patient care deteriorated, professional involvement was reduced or eliminated, and state hospitals became repositories for the poor.[10]

Leong tellingly writes, "In the intervening years (since Kennedy signed the Community Mental Health Centers Act into law) the role of the psychiatrist in these centers has changed so much that in many cases the only alternative to ignominy is for competent, conscientious psychiatrists to totally withdraw their services and support from them."[12] Fink and Weinstein further suggest that, "If it is no longer possible to make the community mental health center system an outstanding therapeutic service delivery system we must immediately redefine it so that it will be clearly distinguishable from psychiatric treatment and rehabilitation and each system can proceed to greater definition, autonomy, growth, and achievement."[10] Phillips unequivocally states that, "Something must be done to improve the psychiatric care in these centers or psychiatrists must dissociate from them."[13]

With regard to this current, often deplorable state of affairs, some blame CMHCs for pushing psychiatrists out while others blame psychiatrists for abandoning CMHCs.[14] In either case, Borus observes that, "Psychiatrists, always on the 'professional fringe,' were mysterious enough to be sent, 'crazy' enough to go, and, as shown in recent years, easy enough to disown if things did not work out."[8] Clearly, if things are to work out and the separatist alternative alluded to by the above authors is to be averted, CMHCs and psychiatrists must collaborate to resolve their differences. Psychiatrists can no longer allow themselves to be "disowned." Indeed, Ruiz has suggested that the deprofessionalization and the demedicalization that have prevailed in CMHCs is in large measure the result of psychiatry's lack of initiative and commitment toward these programs.[15]

Role Conflict

Conflict regarding the psychiatrist's role has become an increasing problem within many community mental health settings. With increasing utilization of nonmedical therapies and increasing sensitivity to the nonmedical influences on

behavior, the traditional hierarchical relationships among the mental health professions has been challenged, according to Brown and Goldstein.[16] Arce and Vergare describe how such role conflict emerged:

> "Before the 1960s, relationships among the mental health professionals — psychiatrists, clinical psychologists, psychiatric social workers, and nurses — were hierarchically ordered and task assignments were mutually exclusive. Psychiatrists were the unquestioned leaders of the treatment team, psychologists conducted diagnostic tests, social workers did casework (history-taking, home visits, placements, and interagency relationships) and nurses dispensed medication. With the advent of the community mental health movement and the increasing demand for services, the number of professional disciplines as well as the number of nonprofessional technologists on the treatment team proliferated. In the CMHCs interdisciplinary functioning became the rule and a more egalitarian set of role relationships evolved among the various disciplines. Responsibilities depended more on competence and experience than on professional credentials, traditional roles, or professional orientation. The 'psychiatric' team of the postwar era became the 'mental health' team as the community mental health ideology emerged . . . In addition to allowing the shift from ancillary to primary therapist for these professionals, CMHCs opened up new paths for transition into administrative and supervisory positions that previously had been occupied by psychiatrists."[9]

As other mental health professionals have assumed roles previously reserved for psychiatrists, psychiatrists have often been relegated to the task of signing prescriptions, medical records, and insurance forms. Winslow points out that when this felt underutilization of his skills is combined with both perceived hostility from other staff and decreased control over his environment, the psychiatrist may well turn his energies elsewhere.[7] This sequence of events may in turn perpetuate a vicious cycle in which the CMHC can neither attract and retain competent psychiatrists nor maintain quality patient care. Dewey and Astrachan describe this vicious cycle that has typically occurred in many CMHCs:

> ". . . the fewer the psychiatrists in a system, the more difficult it will be for them to do all that they need to do. With fewer psychiatrists, the system will be less able to provide high quality care. Psychiatrists will find it more difficult to recruit other psychiatrists, their work loads will increase, and they will see only the most difficult patients. In this situation even the most dedicated psychiatrists will begin looking for a way out. They may become part-time staff and then leave completely."[17]

Once the downward spiral begins, there is little if anything within the system that can salvage it; rather, there is much to drive it further. For as other mental health professionals assume authorities relinquished by vacating psychiatrists, it is unlikely that they will readily give them back. So it is that many CMHCs now have non-psychiatric "Clinical Directors" in addition to non-psychiatric "Executive Directors." According to Perr, the upshot of this downward spiral is that, "Clearly, over a period of years, the public sector has been deteriorating in terms of quality and quantity of psychiatric health care delivery."[18]

Many CMHCs developed in an era marked by tremendous social pressures toward equality as evidenced by the civil rights and women's movements. This undoubtedly contributed to role-blurring in these centers. Furthermore, psychiatrists, with their high value on autonomous development may have, themselves, fostered such role-blurring. In any event, what ensued has been variously described as "functional egalitarianism,"[19] "pseudo-egalitarianism,"[2] "false egalitarianism,"[8] "expedient deprofessionalization,"[20] and an "orgy of role transvestism."[5] Eaton and Goldstein describe "functional egalitarianism" as:

> ". . . the notion that everyone can do almost everything — all it takes is a warm heart and an extended hand. This role-blurring attitude has significant implications for health professionals who have acquired unique skills, knowledge, and attitudes over long, arduous years of education and experience. It is important to remember that differentiation must occur before true collaboration can take place."[19]

Langsley and Barter partly blame this "pseudo-egalitarianism," in conjunction with the shift from the medical to the social rehabilitation model, for the declining psychiatric presence in CMHCs.[2] As Borus notes, "false egalitarianism" thrives when the psychiatrist's role is not clearly defined. In such situations, the psychiatrist is typically left in an uncomfortable, defensive position within his CMHC.[8]

Further contributing to role conflict were the two major goals of the community mental health movement: to redress inequities in mental health care and to prevent mental illness. From these goals, Arce and Vergare observe that two distinct views of the CMHC mission evolved: one holding that the CMHC is a treatment facility, and the other holding that the CMHC is an agent for social change.[9] Conflict along disciplinary lines developed between those who subscribed to the first view, associated with the "medical model," and those who subscribed to the second view, associated with the "human services model." The degree to which the latter view has prevailed is evidenced both by the tendency for CMHC patients now to be called "clients" and by the fact that JCAH standards for CMHCs have been based on the "human services model" and were written in sociological rather than medical language. One might wonder if the minimizing of the medical illness basis of major psychiatric disorders may have been, at least in part, in the self interest of non-physicians who vied with physicians for power and control within CMHCs.

Additional impetus toward the polarization between the medical and human services views of the CMHC mission was provided by PL94-63 which required community control of CMHCs, thus changing the role of community boards from advisory to governing. Community residents began to redefine the CMHC mission, with many viewing centers as agents of social change and emphasizing prevention rather than treatment.[9] Schlosberg notes that, in the name of egalitarianism, CMHC boards were comprised of community residents, nearly all of whom were non-professionals. An anti-professional attitude developed as many board members regarded themselves as "watch dogs," asking professionals for explanations regarding professional matters and even trying to dictate treatment.[21]

Exacerbating the role strain experienced by the CMHC psychiatrist are the ethical and legal binds with which he is faced. Even though the psychiatrist frequently has no final decision-making power over treatment, he is expected to 'sign off' on forms indicating approval of the treatment plan; in such situations not only does role conflict escalate, but also serious questions of fraud sometimes result.[9] There are alarming reports that some CMHC psychiatrists are asked to sign prescriptions and insurance forms for patients they have not seen or evaluated personally.[22,23] It is thus evident why community mental health has been "criticized as 'second-class psychiatry' that substitutes quantity for quality care."[8]

Further indicting the system, Langsley reports that some CMHCs have dangerously few psychiatrists and, of these, many are only part-time physicians who have been trained in foreign countries.[24] Perr implies that the increasing concentration of foreign medical graduates (FMGs) practicing in the public sector may correlate with decreasing quality of care.[18] FMGs, often faced with limited options, may feel more at the mercy of systems which use and abuse them.

Some non-psychiatric CMHC professionals claim that supervision ought not to be left to the psychiatrist as "only a 'substandard' psychiatrist would practice there."[13] While this criticism may not be without merit, since centers are having increasing difficulty recruiting and retaining competent psychiatrists, it may belie tacit approval of the downwardly spiraling process that keeps the psychiatric role within the CMHC minimized and neutralized. Insisting that "the psychiatrist has no unique skills and cannot be viewed as having any greater competence" than a clinical psychologist in such areas as "diagnostic interviewing," one psychologist decries the "myth of the psychiatrist as the super-mental-health-professional."[25] However, insisting that expertise between various disciplines is similar does not make it so. Also contending for equal privileges without equal credentials, one social worker insists that because his is among the "recognized mental health professions" he, too, is qualified to be a team leader.[26] According to such reasoning, a scrub nurse, as a recognized health professional, ought to be allowed to lead a surgical team. Psychiatrists practicing in CMHCs meet with a unique problem not encountered by other medical practitioners, for as Ribner, also a social worker, aptly observes, "In perhaps no other medical specialty does the physician find himself expected to work as a team member with those who are jealous of his power and certain that their abilities equal his."[4]

Generating even greater concern, it has not been uncommon for non-professionals without any graduate credentials to replace professionals in typically professional roles. Dumas, a psychologist writing in the mid-seventies, puts this "slippery slope" into perspective and makes a prediction:

> "It is a heady experience for a young person with a B.A. or B.S. to become a primary therapist, intervening in the lives of people. Too often his or her initial reticence turns into a kind of pseudoprofessional boldness. Psychiatrists, as highly qualified professionals, are in great demand and are very busy; relatively naive politically, they are no match for large numbers of nonmedical mental health workers in any political confrontation. Because of this, the medical model is being displaced by the nonmedical model, and in the near future the nonmedical model will be displaced by the antimedical model until certain political goals of the new federalism are reached. Following this, it seems reasonable that a more realistic assessment will be made and a return to the qualitative superiority of the medical model will occur . . . In the long run this transition should be good for medical and nonmedical mental health professionals as well as the general public."[27]

Movement along such a continuum occured within an Australian CMHC. When interviewed in 1975 the staff felt that the clinic should be committed to a "non-hierarchical, non-bureaucratic, non-medically dominated approach,"[28] with all professional staff working as "generalists" of equal status. Differences among the various professions were diminished and roles were blurred. The democratic team approach to decision-making was based on a rationale that a number of brains are better than one and that a variety of viewpoints contribute to the wisdom of a decision. However, as Tourlentes points out, with "multi-disciplinary leadership" came a great deal of confusion, compromise, and competition, with quality care suffering in the process.[6] It is not surprising that, during the three year period the Australian CMHC was studied, the highest turnover occurred in the medical officer positions.[28]

The "consulting" psychiatrist on such a democratic team was seen by the authors to be in a no-win situation, for he was regarded either as weak and democratic or strong and autocratic.[28] Such a so-called "consulting" psychiatrist, who often works part-time for a CMHC as just another member of the "multi-disciplinary team," is not a consultant in the traditional, medical sense. Unlike the consulting physician whose recommendations may be implemented or not by the primary physician who is responsible for the patient's care, the "consulting" CMHC psychiatrist is held medico-legally responsible by peers and courts. Society insists upon having point responsibility in matters involving morbidity and mortality. In medicine as well as the military, hierarchies have been developed that clearly tie responsibility and authority to certain levels of competence as designated by title or rank. While officers might seek input from subordinates, clearly a military system could not reasonably function if its officers had to go along with majority rule and yet be held personally accountable. Point accountability is essential both in the military and in medicine because life and death crisis situations frequently arise which require rapid, responsible decisions. Such situations do not lend themselves well to cumbersome, time-consuming, group processes.

By the third year of the Australian study, the service adopted a more clinical position and "role-blending" replaced "role-blurring" as increased "disciplinary differentiation" emerged.[28] Such role clarification is crucial if everyone's degree of expertise is to be appropriately recognized and utilized.

Because the psychiatrist is such a scarce and costly commodity, it is all the more imperative that his role be carefully defined. The psychiatrist's comprehensive skills, many of which are unique among the various mental health professionals, will be reviewed later.

Du Mas, the aforementioned psychologist, acknowledges that,

> "Generally speaking, M.D.s certified in psychiatry are the people most competent to treat mental illness. By law and training they are the only ones qualified to treat the whole person: with drugs, organically, surgically, psychologically, and socially. There is no doubt in my own mind that the medical model is qualitatively superior."[27]

Additionally one layman notes that, "Despite the numerous attacks on it, the medical model at its best does offer something in thoroughness of care and a desirable conservatism."[29] Aside from the less than adequate care which is likely being delivered by those nonmedical CMHC practitioners who practice with minimal or no psychiatric supervision, one might well wonder about the possible active harm being done to patients.

Complaints By CMHC Psychiatrists

In a 1976 national survey of CMHC psychiatrists by Reinstein, only 18% of respondents expressed satisfaction with their positions and only 21% stated that they planned to continue in them indefinitely. Among their complaints were the following: 1) being restricted to a nonpsychotherapy role consisting primarily of prescribing medication or consulting with nonmedical therapists ("the non-medical therapists were not adequately qualified for psychotherapy or were not empathic enough in dealing with patients"); 2) being responsible to a nonmedical director and not having enough input into program planning ("One psychiatrist said he complained to the administrative director that the clinic overemphasized bingo games, requiring patients to participate whether they wished to or not; he was told that bingo was emphasized because it increased the clinic's total number of visits, which meant additional funds could be obtained."); and 3) lack of adequate facilities ("One [respondent] complained that there was no office assigned to him and he virtually had to beg for space to do his interviews. Another complained that he had no privacy for interviews. Still another said he had no security for his books and medical supplies, which were frequently stolen.").[30]

Other frequent complaints by psychiatrists regarding CMHCs include: heavy workloads with overscheduled appointments; lack of ongoing clinical relationships with patients; too many bureaucratic hassles; excessive paperwork; lack of peer medical support in non-hospital based centers[2]; insufficient time to provide regular supervision to other clinical staff; lack of adequate training for the administration that is required[31]; lack of autonomy with little control over the work done; frequently being interrupted at a moment's notice to deal with high stress crises of other therapists' patients, about whom the psychiatrist may know nothing; low income and status as a public employee; few opportunities for continuing education due to tight budgets; excessive direct service demands[32]; difficulty functioning as a member of a multi-disciplinary team[33]; feeling resentment from other staff because of psychiatrists' higher pay and status, even though they usually earn less money than they could in private practice; feeling that self and family are at greater risk for physical harm by seriously distrurbed, dangerous patients[34]; and not being rewarded by CMHCs for board certification in psychiatry or specialty board certification in administrative or forensic psychiatry (Clark GH: "Burnout and the Struggle to Survive Among CMHC Psychiatrists." Submitted for publication, 1986). Boyts describes another significant problem for CMHC psychiatrists:

> "Operating in the public sector, centers often assume responsibility for unwilling patients and frequently provide court-mandated interventions. Additional emphasis on the least restrictive environment forces an uncomfortable reponsibility on psychiatrists that involves risks usually avoided in hospitals or private practice. Furthermore, psychiatrists may feel they are at the mercy of judicial and administrative systems."[35]

The Exodus Of Psychiatrists From CMHCs

In addition to any or all of the above noted problems, one of the major reasons why psychiatrists ultimately feel compeled to leave CMHCs is, as Talbott observes, because of constraints on the psychiatrist's ability to upgrade or, I would add, even maintain the quality of care within the system. Responsibility to treat the most severely and chronically mentally ill is not accompanied by the authority to do the job.[36] Neither do they have the time; the CMHC psychiatrist frequently feels pressured not only to do medication checks to the exclusion of vital oversight functions, but also to do more med checks in shorter periods of time, thus risking mistakes and malpractice suits. In its position paper, "Community Mental Health Center Psychiatry," A Subcommittee for CMHC Psychiatry of the North Carolina Neuropsychiatric Association summarized the current, deplorable state of affairs: "Community psychiatrists also deal with isolation, lack of administrative support, interprofessional rivalries, and a cultural climate which sometimes blames psychiatrists for all the problems of patients . . . It is no surprise that 'burnout' occurs with predictable regularity and that psychiatrists either leave centers or become demoralized or, worse yet, sometimes give in to pressures to practice poor medicine."[37]

To date there has been no systematic, nationwide effort to redress the serious problems present in many CMHCs. Problems in recruitment and retention of psychiatrists in these settings continue to escalate. A psychologist from a CMHC in the mid-West recently called the central office of the American Psychiatric Association seeking help in recruiting a psychiatrist; he had been searching for a year. He expressed the belief that the reason he is having such difficulty is that psychiatrists are thinking that CMHCs are not going to survive (Haas-Yamure S: personal communication). Ribner reports that a CMHC medical director

> ". . . ruefully discussed (with him) the coming and going of ten psychiatrists in the past four years... For most of these psychiatrists, it was their first full-time position after residency training or military service. They had come into a community setting after at least seven years of ever-increasing responsibility and prestige in institutions where the physician held ultimate control. They were generally unprepared for the new situations they face at the community facility: supervision by nonmedical personnel, unclear job definitions, nonmedical reponsibilities, and participation by community members. In addition, they encountered distinct enmity from other staff members because of such factors as their higher salaries and shorter expected work week. It was as if each new psychiatrist began with a debit that had to be paid off before he or she could be accepted by the staff. Those committed to a community-care philosophy may be willing to pay such an entrance fee; others, however, find it easier and more profitable to go elsewhere."[4]

According to NIMH data, between 1970 and 1977 the proportion of psychiatrists to all community mental health center staff dropped by 36%, from 9.2% to 5.8%.[38] Furthermore, between 1970 and 1976, while there had been a 64%

increase in the number of of full-time equivalent (FTE) psychiatrists, there were overwhelmingly offsetting increases in FTE nurses of 131%, social workers of 239%, and psychologists of 352%![39] The mean number of FTE psychiatrists per center has progressively declined from 6.8 in 1970 to 3.8 in 1981. Also, in 1971 55% of CMHCs were headed by psychiatrists; by 1980 this figure had steadily declined to 16%.[17] By 1985 this figure had declined even further to 8%.[40] Psychiatrists have been replaced as executive directors by psychologists and public administrators, and even by clergymen, lawyers, and lay people.[34]

According to additional NIMH data, it was estimated that in 1976 there were 3,738 psychiatrists practicing in federally funded CMHCs. Of this only 1,227 (33%) were full-time.[41] NIMH data gathered between 1973 and 1981 suggest that there has been a shift toward greater part-time employment of psychiatrists by CMHCs; this is in contrast to psychologists, social workers, and registered nurses whose shift has been toward greater full-time employment.[42] Beigel reports that there is evidence to suggest that the role of part-time psychiatrists is different from that of full-time psychiatrists.[43] Part-time CMHC psychiatrists are frequently relegated to narrow roles which fail to fully utilize their comprehensive expertise.

Ruiz and Tourlentes indicate that less than 5% of reportable CMHC professional service hours are provided by psychiatrists.[20] The reduction in the ratio of psychiatrists to patient population has raised concerns about the quality of care that can be offered.[9] Frank, an economist, notes that one simple measure of the shortage of CMHC psychiatrists is the number of employment openings.[44] According to Koran, with public psychiatric institutions experiencing an efflux of mid-career psychiatrists, vacant positions in CMHCs as well as state mental hospitals are over-represented in the job advertisements for psychiatrists. He concludes that, "These numerous vacancies are undoubtedly affecting the quality of care."[45]

Notably, general hospital-based CMHCs attract and retain psychiatrists better than non-hospital based CMHCs. In 1981, the average number of FTE psychiatrists in hospital-based CMHCs was 6.7 compared with a mean of 3.5 in all other CMHCs.[17] Additionally, a 1983 survey of CMHCs suggests that there is an inverse correlation between the number of FTE psychiatrists a center has and the degree to which the center perceives itself as having problems with psychiatrists. Centers in which the number of FTE psychiatrists represent only 3% of the total staff perceived themselves as having significant problems with psychiatrists, while those centers whose FTE psychiatrists represent 8% of the staff reported no problems with psychiatric staff.[43] Another revelation of this study is that turnover of all staff was twice as high in CMHCs that had perceived problems retaining psychiatrists.[35] Such turnover of psychiatrists and other staff is terribly costly, not simply in monetary terms, but more importantly in terms of patient morbidity. Substantial and frequent staff turnover seriously compromises continuity of care, upon which the chronically mentally ill patient often desperately depends.

The psychiatric exodus from CMHCs has also manifested itself at the training level. Between 1970 and 1976 the percentage of psychiatry trainees in centers dropped from 29% to 13.8% of the total number of trainees while that of psychology trainees rose from 9.5% to 19.2% and that of social work trainees increased from 19.9% to 24.7%.[46] Medical schools have often been reluctant to sponsor and operate CMHCs, so Winslow reports, because they are "often organizationally complex, fiscally frightening, and administratively taxing to a department of psychiatry."[7] Because departments of psychiatry have often been at odds with the non-medical executive directors and lay boards of directors of CMHCs, many have loosened or severed their affiliations with CMHCs. Indeed, many residency programs in the public sector have disappeared over the past few years.[35] In those residency training programs that do continue to offer rotations in CMHCs, commonly, according to Diamond and Cutler et al, "residents must contend with staff who seem jealous of them, who claim to be more skilled than they are, who often act angry rather than respectful, and who at the same time seem to want a lot of help, encouragement, and support."[22] Boyts expresses concern that attracting medical students to public psychiatry is doubly difficult already without these additional negative experiences: students are often told that they will be wasting their medical education if they go into psychiatry; those who do choose psychiatry seem to be less interested in working in the public sector because of its low status.[35] And so the would-be community psychiatrist, already swimming against the medical mainstream, often finds himself inadequately prepared for the trenches of community mental health.

Further compounding the training dilemma, Diamond and Cutler et al note that, "In addition to a lack of interest, there is a general lack of knowledge about the public sector among academicians."[22] Biological programs often do not adequately attend to training in administrative and community processes, and analytic programs focus upon therapy for the individual with generally little regard for the contextual systems. Diamond and Cutler et al advocate that the "generalist position" be supported if residents are to become interested in working with the chronically mentally ill, since adequately treating these patients requires a very broad perspective.[22]

Langsley warns that, "the CMHC cannot expect to solve its staffing problems by prostituting the student for service, nor can the academic department benefit from using the student for financial gain."[14] The elimination of new funds for National Health Service Corp scholarships and the current administration's cutting of training grants have, according to Diamond and Cutler et al, exacerbated the grave psychiatric recruitment problems that already exist in CMHCs.[22]

Defining The CMHC Psychiatrist's Role

In 1977, the Special Assistant to the President for Health Issues judged that if psychiatrists are to gain the public trust, they must determine for themselves what unique skill they have to offer and how they can best provide, in an effective and credible way, their knowledge and expertise to the public.[47] Arce and Vergare point out that agreement on the CMHC psychiatrist's job description, with definition of authority and responsibility, is essential if psychiatrists and co-workers are to cooperate in a clinically effective and professionally satisfying way.[9] Referencing the survey of nearly 500 psychiatrists conducted by Langsley and Hollender,[48] Langsley and Barter succinctly describe the major functions of the psychiatrist:

> "The psychiatrist is a physician who can conduct a comprehensive psychiatric interview, make accurate diagnoses of mental disorders, evaluate the need for hospitalization, formulate and implement a treatment plan, assess the potential for suicide or homicide, order and interpret laboratory tests, provide psychotherapy, use psychoactive drugs competently, perform a thorough physical examination, do family interviews, evaluate the interaction between physical and mental illness, treat psychosomatic problems, do liaison psychiatry, maintain adequate medical records, teach colleagues and students, and work harmoniously as a member of a mental health team."[2]

As previously noted, the last of these psychiatric functions can be problematic in a CMHC. Other authors offer additional definitions of the psychiatrist's role.[40,49]

Unless the psychiatrist is somehow able to demarcate the consulting role, as in the traditional, medical sense (which seems unlikely in CMHCs where many clinical staff are not licensed to practice independently), the psychiatrist, given his medico-legal responsibilities and fiduciary responsibilities to third party payers, clearly must function as the team leader rather than simply as a team member. In the wake of deinstitutionalization, the psychiatrist has become increasingly vital to the success of the community mental health system. With expanded responsibility for the severely and chronically mentally ill, CMHCs require, now more than ever, the psychiatrist's ability both to integrate the biological with the psychosocial aspects of severe mental illness and to facilitate this population's accessing the general health care system.[23] It has been estimated that 2 million Americans have a diagnosis of schizophrenia, 2.5 to 4 million suffer from depressive disorders, and over 1 million have organic or other permanently disabling mental conditions.[46]

Talbott, a long standing advocate of the chronically mentally ill, says that, "Attempts must be made to stem the tide of demedicalization by returning physicians to a more active, responsible role instead of relegating them to writing prescriptions, conducting physical exams, and providing signatures for legal documents."[36] Regarding the psychiatrist's appropriate role on the team, Tourlentes writes,

> "The properly organized psychiatric team must not be an amorphous amoeba-like creature capable of moving in all directions. It should have a rational and consistent structure, predicated as much on significant professional differences as on incidental functional similarities. The discipline with the greatest responsibility, psychiatric medicine, should have ultimate authority, and should be prepared to exercise that authority in a fair and effective manner. However, we should not compromise our medical responsibilities merely to please those who seek parity where none exists."[6]

He goes on to say that "multi-disciplinary leadership" must give way to "interdisciplinary teamwork."

According to the "Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists" developed by the American Psychiatric Association, "The psychiatrist remains ethically and medically responsible for the patient's care as long as the treatment continues under his or her supervision."[50] Arce and Vergare point out that,

> "Such a relationship is often required by insurers and licensing standards. With the physician in ultimate charge of the treatment, it is implicitly understood that he or she can choose the therapist who will carry out a plan of treatment. Thus the therapist functions as a 'physician extender' rather than a 'physician replacer.' "[9]

Boyts, a social worker who authored the executive summary for the report of the Joint Steering Committee of the APA and the National Council of CMHCs entitled, "Community Mental Health Centers and Psychiatrists," writes, "All authors

agree that role definitions must be clearly understood so that psychiatrists have authority commensurate with the responsibility assumed."[35] Dewey and Astrachan similarly insist that the psychiatrist have overall responsibility for evaluation, diagnosis, and treatment planning of the medical care of patients.[17]

One must then ask, "How broad is the scope of medical care within a CMHC and how far does medical responsibility and authority for care extend?" There can be no doubt that given the severely and chronically mentally ill population CMHCs are now expected to treat, these CMHCs must become, if they are not already, true health care facilities as well as social service agencies. According to Pardes and Stockdill, we can no longer afford to view the "medical" and "human service" models as dichotomous; rather the complementary potential of the two must be recognized.[39] The provision of comprehensive care that addresses the patient's biological as well as psycho-social rehabilitation needs is a goal toward which CMHCs must strive. Indeed, CMHCs may be uniquely suited to realizing this ideal.

However, it must firstly be understood that inadequate treatment of a patient's biological impairment precludes the possiblity of successful psycho-social treatment and rehabilitation. The latter two can only be built upon a stable foundation provided by the former. Looked at another way, a person's biological status is like the hardware in a computer. It is a given that the hardware must be operational before any software applications can be made.

Secondly, it must be understood that ultimate clinical responsibility and authority for any and all clinical programs, biological, psychological, and social, must rest with the professional who both has the necessary comprehensive expertise and is mandated by the legal system and third party payers to assume such responsibility and authority. Only the psychiatrist has these qualifications. Every mental health center ought, therefore, to have a psychiatric medical director whose clinical oversight role with those providing psycho-social rehabilitative treatments is akin to that which he would have with nursing staff on a psychiatric inpatient unit in a hospital. While nurses have special expertise, skills, and standards, their part in the total care of the patient necessarily falls under the purview of the physician who is ultimately reponsible for that patient's care. The North Carolina group unequivocally states the following regarding this issue: "Each community program must have a psychiatrist as medical director with the overall and ultimate reponsibility and administrative authority for treatment and care of all patients. He/she must have direct access to the governing body — perhaps along the lines that hospitals have used — governance jointly by medical staff and hospital administration."[37]

Further elucidating the appropriate role of the CMHC psychiatrist, this group goes on to say that, "All patients admitted to the mental health center should have an evaluation by a psychiatrist. The psychiatrist determines if a psychiatric illness exists, excludes any medical problems or complications, and collaborates with other staff in treatment."[37] Regarding this critical issue of evaluation, Borus indicates that correct evaluation, from which appropriate treatment can then proceed, is the essence of 'first-class psychiatry.'[8] The North Carolina group additionally notes that CMHC psychiatrists must be involved in plannning and developing services both at the community level as well as within the center. Lastly, this group urges CMHC psychiatrists to speak for the needs of chronic patients at both the local and state levels, to liaison with local physicians to ensure good medical care for their patients, to liaison with state hospital physicians to ensure continuity of care, and to participate in peer review and other mechanisms of quality assurance.[37]

Additional Strategies For Recruitment And Retention

Perr surmises that increasing dissatisfation by the public may help to reverse the decline in quality within the public sector.[18] In the meantime, according to the North Carolina group, "Steps to prevent further deterioration of patient care include . . . the formulation of appropriate standards of psychiatric practice in CMHCs . . . There should be standards for care comparable to those in any good medical care facility."[37] Such standards might include the assurance of every CMHC having a medical director whose clinical oversight role is clearly defined, standards regarding clinical supervision, and standards regarding appropriate psychiatric staffing ratios, both to patients and to other clinical staff. In that good care cannot be provided when a physician has an overwhelming patient load, it stands to reason, according to the North Carolina group, that any given psychiatrist can only be responsible for a finite number of patients. They go on to recommend that a determination of what constitutes a reasonable caseload for a CMHC psychiatrist be made through careful study.[37] Beigel et al recommend that staffing standards include "appropriate ratios of psychiatrists to the other clinical staff members," and, furthermore, that "an appropriate staffing standard of psychiatrists . . (be) . . a condition for eligibility as an organized care provider."[51]

Beyond the development of standards, Beigel et al suggest other strategies to increase psychiatric involvement in CMHCs. They urge that centers provide the psychiatrist with time to do research, supervision, and teaching. Toward this end, offering faculty appointments in medical schools can be attractive to psychiatrists. Such appointments also serve to upgrade the image CMHC psychiatrists and the CMHCs, themselves. Departments of psychiatry need to reorient their

training programs and help the trainee to understand that doing medical assessments is not demeaning. What is demeaning is restricting the psychiatrist's role solely to this function and failing to take advantage of the broader ripple effect that his expertise could provide were it used appropriately through the provision of supervisory oversight and clinical program planning. The psychiatrist should be encouraged and prepared to enter CMHC administration.[37,7] CMHCs would do well to reward psychiatrists who have attained administrative as well as general or forensic psychiatry board certification. Koran suggests that additional strategies include creating varied job responsibilities and being committed to providing high quality care.[45] Finally, Beigel et al have advised that an organizational entity be developed with specialized educational programs for CMHC psychiatrists.[51] The American Association of CMHC Psychiatrists, formed in 1984, has this as one of its purposes.

Toward the clearly needed end of increasing psychiatric involvement in CMHCs, Langsley and Barter have outlined the responsibilities of centers, psychiatric training programs, the psychiatric profession, and government.[2] Each of these areas will be similarly addressed, followed by a discussion of the responsibilities of CMHC psychiatrists, themselves.

Responsibilities of Centers

Langsley and Barter urge "Centers . . . to make a commitment to the provision of quality care to 'all' the mentally disordered . . . Centers that cannot or will not responsibly treat the seriously mentally ill will continue to perpetuate the scandals of deinstitutionalization, and will suffer from being characterized as little more than counseling centers for the not-so-ill."[2] Given that 5 to 15 percent of patients have a physical disease causing their mental symptoms, and that an additional 20 to 50 percent suffer from physical diseases that coexist with or exacerbate their mental disorder,[52] it is critical that this patient population be medically evaluated for possible underlying and/or associated medical conditions. A screening of over 2000 psychiatric clinic patients, reported by Koranyi, showed that 43% of this population suffered from one or several physical illnesses, and that "social agency-referred patients almost always had undiagnosed physical illnesses."[53] The need for CMHCs to become more medically sophisticated is clear.

This need is certainly evident to the relatives of the mentally ill. According to James Howe, Immediate Past-President of the National Alliance for the Mentally Ill, an organization with more than 40,000 member-families, many CMHCs have failed to respond adequately to the needs of the mentally ill (Address to the American Association of CMHC Psychiatrists at its Annual Meeting, May 11, 1986). Not surprisingly, many family members now prefer to have their mentally ill relatives be identified as "patients" rather than as "clients" or "consumers." As "clients" and "consumers," many of the mentally ill have not received the appropriate medical treatment they require. Busick notes the following:

> "More than 250 medically recognized diseases or conditions can cause . . . brain dysfunction . . . The CAMI (Colorado Alliance for the Mentally Ill) members advocate medical screeening as a first step in reshaping the care of the mentally ill. The ultimate goal is removal of the stigma suffered by their children and themselves. They believe this will most successfully be accomplished when chronic mental illness is recognized as the physical illness it really is."[54]

Back in 1972 the American Psychiatric Association said the following in its "Position Statement on Community Mental Health Centers": "Because of the disproportionately high incidence of unmet needs for medical care of physical illness in psychiatric patients, because of the greater acceptability of psychiatric care under a 'medical' rather than a 'mental' aegis, and because of the inseparability of various forms of mental and physical medicine in large numbers of patients, it is necessary to establish close working relationships with the medical community in general and specifically with comprehensive medical centers, where they exist."[55] Langsley and Barter also advocate that centers "reaffiliate with the health care delivery system," specifically with a community hospital or similar health care facility. Dewey and Astrachan additionally recommend that CMHCs, themselves, "behave more like health care facilities."[17] Aside from providing the medical care required to treat the seriously and chronically mentally ill, such measures, if taken by centers, would go a long way toward attracting competent psychiatrists. Physicians value participation in institutions that, in turn, value the provision of quality care.

Centers must strive harder to enhance the general job satisfaction of psychiatrists if they wish to promote the recruitment and retention of them. Langsley and Barter suggest that,

> "Job satisfaction is an important element in the retention of psychiatrists in CMHCs. Since it usually takes more than ten months to recruit a psychiatrist, retention becomes of vital interest to the centers. Job satisfaction derives from the respect and appreciation of one's colleagues as well as from responsibilities appropriate to one's clinical skills and competence. Being meaningfully involved in treatment, sharing administrative responsibility, and providing clinical leadership are among the proper roles for the psychiatrist."[2]

Again, regarding this critical issue of appropriate role definition, a recent report by the Group for the Advancement of Psychiatry (GAP) advocates that, "Psychiatrists ought to be involved in the planning, implementation, and monitoring of all programs to prevent the blurring of programmatic focus and lines of professional responsibility."[56] The APA, in its CMHC position statement, admonishes, "It is important . . . if high standards are to be achieved in the quality of care that is rendered, to avoid operating on the false principle that 'anybody can do anything.' The limits of the roles, responsibilities, and skills of professionals and paraprofessionals should be delineated."[55] A more recent report of the APA's Task Force on Community Mental Health Programs, "strongly recommend(s) that community Mental Health Programs have privileges and credentials committees that screen all professional staff, recommending acceptance for specific therapeutic modalities based on those individual qualifications."[57] Brill describes what must occur in a medical setting, which CMHCs must increasingly become if they are adequately to treat the mentally ill:

> "In a medical setting the psychiatrist is required by law and custom to retain primary responsibility for the admission, diagnosis, treatment, rehabilitation, and discharge of patients. He is bound by hospital accreditation rules, medical staff policies, bylaws, ethics, oaths, and legal responbsibilities. Many specialized activities can be delegated to allied professionals, but the physician is trained to be captain of the team."[58]

According to the APA position statement, while the center's, like the hospital's, chief executive officer need not be a physician, the psychiatric treatment program must be under medical oversight.[55] Such clinical leadership must, according to Astrachan, be intimately related to institutional management, speaking for and insisting upon quality care.[59]

An appropriately defined role is essential for the CMHC psychiatrist's job satisfaction. Diamond and Cutler et al point out that job satisfaction is further enhanced by providing better for continuing medical education needs.[22] According to licensing standards, physicians must meet rigorous continuing medical education requirements. Heretofore, many CMHCs, unlike most other settings which employ physicians, have failed to provide both adequate time for conference leave and adequate reimbursement.

Diamond and Cutler et al also suggest, since the CMHC psychiatrist's hourly income is between 1/2 and 2/3 of what they could expect from private practice, that salaries be more closely tied to the going rates in the surrounding psychiatric community.[22] Langsley and Barter insist on a more "realistic approach" to CMHC psychiatrists' salaries. They contend that, in contrast with CMHC psychiatrists, nonpsychiatric CMHC professionals receive salaries comparable to what they might expect in most other settings.[2] As Donovan says, "It is unrealistic to rely solely on dedication to sustain community psychiatrists . . . While money does not guarantee happiness, it acts as a buffer during stressful periods when the job itself is less gratifying."[31] Notably, Lehman and Lehman found that while normative factors (e.g., commitment to public service) may attract some psychiatrists to community mental health, there is little prospect for substantial growth in the ranks of career CMHC psychiatrists as long as utilitarian (e.g., economic) disincentives persist.[60] Borus points out that, "if the other types of rewards are inadequate, altruism wears thin and 'burnout' begins as the community psychiatrist discovers that the reverse side of altruism is masochism."[8] Where psychiatric salaries are "held unrealistically low," Tourlentes warns that "ambivalent attitudes become self-fulfilling prophesies, and psychiatrists do not come where they feel useless and unwanted."[6] With the current national psychiatric manpower shortage, there are plenty of "greener pastures" for competent psychiatrists.

In addition to or in lieu of increasing salaries, Frank suggests that the work week might be shortened to allow the psychiatrist to pursue other valued activities.[44] These might include teaching, research, and some private practice. Full-time private practice would hopefully not be the ultimate goal of the CMHC psychiatrist, yet may well serve as an enriching part-time adjunct. If the psychiatrist feels personally and professionally enriched in his role within the CMHC, he is much less likely to use the CMHC as a "stepping stone" to a "greener pasture."

Responsibilities Of Psychiatric Training Program

Langsley and Barter report that while psychiatrists should receive part of their training in CMHCs, given that centers are an important part of the health care delivery system, few psychiatric residency training programs include exposure to CMHCs, and those that do often send residents to them only for brief rotations.[2] Furthermore, because of frequent incompatibility between CMHC goals and quality psychiatric education, the CMHC experiences which many trainees have are negative ones. According to Faulkner and Eaton et al, a number of medical schools have terminated relationships with CMHCs as residency training sites because of concerns about pressure for service, role diffusion, isolation, and the movement of CMHCs away from the medical model; additionally there have been fiscal, logistical, and contractual concerns.[61]

Talbott advocates that medical students and psychiatric residents receive adequate training, which they currently lack, in public psychiatry and psychiatric administration.[36] Langsley emphatically states that, "ALL psychiatrists ought to get a significant clinical experience in such a center."[24] One way that this might be assured would be to have a significant community mental health experience be a prerequisite for certification by the American Board of Psychiatry and Neurology. Also, Winslow urges medical schools to strengthen and remain heavily committed to their affiliations with CMHCs. This would serve to reassure residents that psychiatrists do have meaningful roles in CMHCs. Hopefully it might even encourage residents to choose community psychiatry as a career.[7] However, this will occur only if, as Rankin states, the training site is

> "a place where good psychiatry is practiced. There should be at least one full-time psychiatrist on the staff of the center, and he should be enthusiastic about what he is doing. He should be a skilled clinician and educator, and should be on the clinical faculty of the medical center. If he is writing papers of substance and/or doing meaningful research, so much the better."[33]

Such fulfilled CMHC psychiatrists can play a critical role in the recruitment of trainees who, as Dewey and Astrachan point out, are attracted to certain settings based upon positive experiences with interested, motivated role models.[17] Diamond and Cutler et al expand upon the significance of positive role models:

> "Learning is a matter of identification; in every profession students imitate the teachers whom they most respect. Skills and roles associated with community mental health need to be framed and modeled as 'high prestige,' a task which only very skillful professionals can achieve. Such promotion will help to counteract current beliefs that attach a low status to public sector work."[22]

Some authors urge psychiatry departments to take advantage of the unique training activities CMHCs have to offer in the areas of administration, forensic psychiatry, supervision of other professionals, consultation to community agencies, and serving rural, poor minority, and chronically mentally ill patient populations.[61,35] In an effort to afford the psychiatric trainee with the unique opportunity of witnessing how a system is managed at its highest level, other authors suggest that residents be allowed to participate on the CMHC board as an ex-officio member.[62,22] This would help the trainee to gain a broad understanding of issues related to community mental health and also convey that his participation is valued, two necessary ingredients to prepare the resident for and attract him to community psychiatry.

Dewey and Astrachan note that centers which are affiliated with medical schools report that such affiliations make it much easier to recruit and retain skilled psychiatrists. Reasons suggested for this include the prestige and option to teach that faculty appointments provide, along with the stimulating colleaguial relationship, rich continuing education opportunities, better research opportunities, and extensive library services which medical schools provide.[17]

Responsibilites Of The Psychiatric Profession

Donovan writes that, "The CMHCs and the brave clinicians who work in them need the affirmation of their colleagues and the whole society."[31] Unfortunately, however, CMHC psychiatrists are often viewed by their psychiatric colleagues as American soldiers fighting in Viet Nam were viewed by their countrymen. Just as Americans were largely critical of the Viet Nam war, so have psychiatrists been largely critical of CMHCs. As the GAP report puts it, while "In its early days,

many prominent psychiatrists were eloquent voices for the CMHC program . . . In recent years, psychiatrists have more often been critics than advocates of the CMHCs."[56] As was the case with our Viet Nam soldiers, our CMHC psychiatrists are unsung heroes, doing their best in often impossible situations. They deserve our full support, not our condemnation. Langsley and Barter suggest some ways in which such support might be provided:

> "The American Psychiatric Association and other psychiatric specialty societies should support the concept of community mental health centers as well as the provision of quality psychiatric care in the centers. The societies could do so by defining the roles and competencies of the psychiatrist, by helping recruit psychiatrists to work in centers, and by publicizing centers that are models of excellence of care. Any way in which psychiatry can help to improve the quality of care provided in the centers is of benefit to the patients served and to the general public, and is a proper discharge of the specialty's responsibility to improve the quality of psychiatric treatment."[2]

Responsibilities Of Government

The GAP report levels the following criticisms and makes a recommendation: "For the most part CMHCs are not taking care of the seriously and chronically mentally ill"; public funding has been poured into the elusive goal of prevention while actual treatment and rehabilitation have been neglected. Government must now ensure that our limited resources are directed primarily toward alleviating the suffering that results from mental illness and its consequences.[56]

In obtaining treatment for its charges, government must be concerned that such treatment is delivered in an appropriate and cost-effective manner. Presumably, therefore, government ought to insist on the development of standards of practice in CMHCs. Langsley and Barter describe part of what is needed now and why:

> "The government, and specifically the National Institute of Mental Health, should take the responsibility for establishing staffing standards that mandate an appropriate role for the psychiatrist in the community mental health center, and that require care comparable to what can be obtained in health care facilities or in the private sector. The consequence of failing to set such standards may well be a return to a state-hospital-based system of care, the neglect of the mentally ill in the community, or a situation in which only the affluent will be able to obtain quality care in private hospitals or from private practitioners. The courts and the general public will not readily permit such developments."[2]

Writing of psychiatry generally, and certainly applicable to psychiatric care provided by CMHCs, Sharfstein advocates that standards be developed which hold systems accountable for both the quality and the cost of public care.[63] Leong warns that unless national policy can ensure that every CMHC has a medical director with authorities commensurate with responsibilities and that patients are appropriately diagnosed and comprehensively treated, the recruitment and retention of competent psychiatrists will remain problematic. If psychiatrists cannot provide quality care in these settings, they will be forced to practice elsewhere.[12] Their allegiance to the Hippocratic Oath will not allow them to collude with a system which fails to render proper treatment.

Responsibilities Of CMHC Psychiatrists

While Langsley and Barter did not specifically address this area of responsibility, clearly CMHC psychiatrists must also make a best faith effort to collaborate with CMHCs, psychiatry departments, their professional associations, and local, state, and federal governments if the problems outlined in this paper are to be successfully redressed. For psychiatrists to continue to use CMHCs merely as "stepping-stones" into private practice is for them to remain part of the problem rather than contribute to the solution.

Tourlentes aptly makes another important point:

"Some of our difficulties are the product of political naivete. We tend to think of ourselves as being above petty politics . . . (But) Plato tells us that, 'The penalty of wise men who refuse to participate in government is to be governed by unwise men.' Medicine, and certainly psychiatry, cannot be practiced in a social vacuum. We must play a more active part in shaping and directing the many forces at work around us."[6]

CMHC psychiatrists can no longer afford to sit passively by. They must get involved, if they are not already, in the APA, the American Association of CMHC Psychiatrists, and the National Council of CMHCs.

CMHC psychiatrists will do their patients, their centers, and themselves a service both by doing whatever they can to enhance the quantity and quality of training in community psychiatry and by recruiting skilled colleagues. Community mental health has much to recommend it to the prospective candidate. One group of CMHC psychiatrists noted the following major advantages to working in a CMHC: working with a variety of interesting and challenging cases; having an opportunity to be involved in and provide service to the community; doing consultations and case conferences with a multidisciplinary team; having more opportunities to do group therapy; and having regular hours, a salaried income, and paid conference and vacation leave.[34] Glasscote adds that some psychiatrists, frustrated with unidimensional approaches, may be attracted to the eclecticism which community mental health offers.[29] Donovan notes that working in a CMHC offers the psychiatrist an opportunity to use his or her dynamic understanding of systems to assist the organization wend its way through the crises that inevitably arise.[31]

Conclusion

In 1977, Bourne wrote, "The major challenge to psychiatry in the next decade is to make our skills available to all Americans. A two class system of mental health care cannot be accepted."[47] Almost a decade later, this challenge to psychiatry and those with whom it must collaborate remains. Zussman and Lamb insist that, "Psychiatrists must become more involved in community mental health and should reassert their leadership,"[64] at least with respect to clinical care.

In the late 1970s, Sabshin described community psychiatry as being in the "turmoil of its middle adolescence."[65] Borus adds that, "this 'adolescent' still needs considerable support and resources to develop in a healthy manner."[8] It is encumbent upon all who are involved in community mental health to provide this support and collaboratively help it to resolve its identiy crisis and move on to a mature and generative adulthood.

CMHC psychiatrists must decide whether to go a separatist or collaborative route with respect to CMHCs. Community psychiatrists have power as a group to help change the system, for, without them, centers cannot effectively fulfill their mandate to treat the severely and chronically mentally ill. While the separatist alternative always remains an option, CMHC psychiatrists might do well first to collect as a group (e.g., through the American Association of CMHC Psychiatrists), and then, from a position of united strength, collaborate with such groups as the National Council of CMHCs, the National Association of State Mental Health Program Directors, the National Institute of Mental Health, and the Joint Commission on Accreditation of Hospitals. Shervert Frazier, M.D., the Director of the National Institute of Mental Health, said the following in his address to the National Council of CMHCs at its 1986 annual meeting: " 'Community mental health' connotes a fellowship, a partnership, within our society, and that requires a strong sense of respect and trust among the many parties who comprise the mental health system, including the mentally ill. Maintaining the trust can be difficult in the face of change — particularly when that change directly affects the roles and responsibilities of the partners — but it is essential if we are to continue to grow and to do what we do well."

The era of adversity within CMHCs must draw to a close. The CMHC psychiatrist can no longer feel like and be perceived as a "necessary evil."[66] The time is ripe for psychiatrists and their CMHCs to join forces if they are effectively to manange forthcoming changes in health care delivery, such as "capitation," of which Frazier warns us in the above noted speech. To succeed in fully "Realizing Our Potential" (the theme of the 1986 annual meeting of the National Council of CMHCs) we must recognize and build upon our "Unity Amidst Diversity" (the theme of the 1986 annual meeting of the American Psychiatric Association). Our patients, their families, and the public at large are depending upon us to do just this.

References

1. Kennedy JF: Message from the President of the United States to the 88th Congress. Document 58, Feb 5, 1963
2. Langsley DG, Barter JT: Psychiatric Roles in the Community Mental Health Center. Hospital and Community Psychiatry 34:729-733, 1983
3. Joint Commission on Mental Illness and Health: Action For Mental Health. New York, Basic Books, 1961
4. Ribner DS: Psychiatrists and Community Mental Health: Current Issues and Trends. Hospital and Community Psychiatry 31:338-341, 1980
5. Freedman DX: Community Mental Health: Slogan and a History of the Mission, in Controversy in Psychiatry. Edited by Brady JP, Brodie HKH. Philadelphia, Pa, W.B. Saunders, 1978
6. Tourlentes TT: Psychiatric Administration and Medical Responsibility. Administration in Mental Health 9:154-158, 1981
7. Winslow WW: The Changing Role of Psychiatrists in Community Mental Health Centers. American Journal of Psychiatry 136:24-27, 1979
8. Borus JF: Issues Critical to the Survival of Community Mental Health. American Journal of Psychiatry 135:1029-1035, 1978
9. Arce AA, Vergare MJ: Psychiatrists and Interprofessional Role Conflicts in Community Mental Health Centers, in Community Mental Health Centers and Psychiatrists. Edited by a Joint Steering Committee of the APA and the NCCMHC. Washington, DC and Rockville, Md, American Psychiatric Association and National Council of Community Mental Health Centers, 1985
10. Fink PJ, Weinstein SP: Whatever Happened to Psychiatry? The Deprofessionalization of Community Mental Health Centers. American Journal of Psychiatry 136:406-409, 1979
11. Mollica RF: From Asylum To Community — The Threatened Disintegration of Public Psychiatry. The New England Journal of Medicine 17:367-373, 1983
12. Leong GB: Psychiatrists And Community Mental Health Centers: Can Their Relationship Be Salvaged? Hospital and Community Psychiatry 33:309-310, 1982
13. Phillips P: Community Mental Health Centers — Pro and Con. Journal of the Florida Medical Association 68:103-107, 1981
14. Langsley DG: Response and Critique. Community Mental Health Journal 18:15-16, 1982
15. Ruiz P: Response and Critique. Community Mental Health Journal 18:13-14, 1982
16. Brown BS, Goldstein H: The Lightning Rod of Human Service Delivery, in Controversy in Psychiatry. Edited by Brady JP, Brodie HKH. Philadelphia, Pa, W.B. Saunders, 1978
17. Dewey L, Astrachan BM: Organizational Issues in Recruitment and Retention of Psychiatrists by CMHCs, in Community Mental Health Centers and Psychiatrists. Edited by a Joint Steering Committee of the APA and the NCCMHC. Washington, DC and Rockville, Md, American Psychiatric Association and National Council of Community Mental Health Centers, 1985
18. Perr IN: New Multi-Tier System in Psychiatry. The Psychiatric Times 3,#2:1,12,14,19, 1986
19. Eaton JS, Goldstein LS: Psychiatry in Crisis. American Journal of Psychiatry 134:642-645, 1977
20. Ruiz P, Tourlentes TT: Community Mental Health Centers, in Psychiatric Administration. Edited by Talbott JA, Kaplan SR. New York, NY, Grune & Stratton, 1982
21. Schlosberg A: Some Factors and Issues, Concerning Community Psychiatry. International Journal of Social Psychiatry 22:120-129, 1976
22. Diamond H, Cutler DL, et al: Training, Recruitment, and Retention of Psychiatrists in CMHCs: Issues and Answers, in Community Mental Health Centers and Psychiatrists. Edited by a Joint Steering Committee of the APA and the NCCMHC. Washington, DC and Rockville, Md, American Psychiatric Association and National Council of Community Mental Health Centers, 1985
23. Okin RL: How Community Mental Health Centers Are Coping. Hospital and Community Psychiatry 35:1118-1125, 1984
24. Langsley DG: The Community Mental Health Center: Does It Treat Patients? Hospital and Community Psychiatry 31:815-819, 1980
25. Huber H: The Psychiatrist's Role As Team Leader: What About the Other Professionals? Hospital and Community Psychiatry 28:918, 1977
26. Frederick PE: The Psychiatrist/Psychologist As Team Leader: What About Social Workers and Nurses? Hospital and Community Psychiatry 29:326, 1978
27. Du Mas FM: Medical, Nonmedical, or Antimedical Models for Mental Health Centers? American Journal of Psychiatry 131:875-878, 1974
28. Krupinski J, Lippman L: Multidisciplinary or Nondisciplinary: Evaluation of Staff Functioning in a Community Mental Health Centre. Australian and New Zealand Journal of Psychiatry 18:172-178, 1984
29. Glasscote R: The Future of the Community Mental Health Center. Psychiatric Annals 5:382-388, 1975
30. Reinstein MJ: Community Mental Health Centers and the Dissatisfied Psychiatrist: Results of an Informal Survey. Hospital and Community Psychiatry 29:261-262, 1978
31. Donovan CM: Problems of Psychiatric Practice in Community Mental Health Centers. American Journal of Psychiatry 139:456-460, 1982
32. Tucker GT, Turner J, Chapman R: Problems in Attracting and Retaining Psychiatrists in Rural Areas. Hospital and Community Psychiatry 32:118-120, 1981
33. Rankin RM: Response and Critique. Community Mental Health Journal 18:17-18, 1982
34. Psychiatric Exodus From CMHCs: Panel Examines the Causes and Proposes Some Solutions. Hospital and Community Psychiatry 29:407,411,414, 1978

35. Boyts H: Overview — Recruiting and Retaining Psychiatrists to Work in Community Mental Health Centers: Overcoming the Obstacles, in Community Mental Health Centers and Psychiatrists. Edited by a Joint Steering Committee of the APA and the NCCMHC. Washington, DC and Rockville, Md, American Psychiatric Association and National Council of Community Mental Health Centers, 1985
36. Talbott JA: Why Psychiatrists Leave the Public Sector. Hospital and Community Psychiatry 30:778-782, 1979
37. Community Mental Health Center Psychiatry — Position Paper. Durham, NC, North Carolina Neuropsychiatric Association, 1983
38. Berlin RM, Kales JD, et al: The Patient Care Crisis in Community Mental Health Centers: A Need for More Psychiatric Involvement. American Journal of Psychiatry 138:450-454, 1981
39. Pardes H, Stockdill JW: Survival Strategies for Community Mental Health Services in the 1980s. Hospital and Community Psychiatry 35:127-132, 1984
40. Knox, MD: National Registry Reveals Profile of Service Provider. National Council News, Sept.1, 1985
41. Bass RD: CMHC Staffing: Who Minds the Store? DHEW Publication ADM 78-686. Rockville, Md, National Institute of Mental Health, 1978
42. Thompson JW, Bass RD: Changing Staffing Patterns in Community Mental Health Centers. Hospital and Community Psychiatry 35:1107-1114, 1984
43. Beigel A: The Remedicalization of Community Mental Health. Hospital and Community Psychiatry 35:1114-1117, 1984.
44. Frank RG: Is There A Shortage of Psychiatrists? An Economist's View of the Evidence. Community Mental Health Journal 19:42-53, 1983
45. Koran LM, Chinn F, Flores S: Recruitment of Institutional Psychiatrists for the 50 States. Social Science Medicine 17:889-896, 1983
46. Winslow WW: Changing Trends in CMHCs: Keys to Survival in the Eighties. Hospital and Community Psychiatry 33:273-277, 1982
47. Bourne PG: The Psychiatrist's Responsibility and the Public Trust. American Journal of Psychiatry 135:174-177, 1978
48. Langsley DG, Hollender, MH: The Definition of a Psychiatrist. American Journal of Psychiatry 139:81-85, 1982
49. Langsley DG, Robinowitz CB: Psychiatric Manpower: An Overview. Hospital and Community Psychiatry 30:749-755, 1979
50. American Psychiatric Association: Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists. American Journal of Psychiatry 137:1489-1491, 1980
51. Beigel A, Sharfstein S, Wolfe J: Toward Increased Psychiatric Presence in Community Mental Health Centers. Hospital and Community Psychiatry 30:763-767, 1979
52. Koran LM, Sox HC, Marton KI: Mobile Medical Screening Teams for Public Programs. Hospital and Community Psychiatry 35:1151-1152, 1984
53. Koranyi EK: Morbidity and Rate of Undiagnosed Physical Illnesses in a Psychiatric Clinic Population. Archives of General Psychiatry 36:414-419, 1979
54. Busick BS: A New Advocacy for The Mentally Ill. The Colorado Lawyer 13:74,76,77, 1984
55. American Psychiatric Association: Position Statement On Community Mental Health Centers. American Journal of Psychiatry 130:239-240, 1973
56. Committee on Psychiatry and Community of the Group for the Advancement of Psychiatry: Community Psychiatry: A Reappraisal. New York, Mental Health Materials Center, 1983
57. American Psychiatric Association: Report of the Task Force on Community Mental Health Programs. American Journal of psychiatry 139:705-708, 1982
58. Brill NQ: Delineating the Role of the Psychiatrist on the Psychiatric Team. Hospital and Community Psychiatry 28:542-544, 1977
59. Astrachan BM: Regulation, Adaptation, and Leadership in Psychiatric Facilities. Hospital and Community Psychiatry 31:169-174, 1980
60. Lehman EW, Lehman E: Psychiatrists and Community Mental Health: Normative Versus Utilitarian Incentives. Journal of Health and Social Behavior 17:364-375, 1976
61. Faulkner LR, Eaton JS, et al: The CMHC as a Setting for Residency Education. Community Mental Health Journal 18:3-10, 1982
62. Beigel A, Bevan R, et al: The Psychiatric Resident As An Ex-Officio Community Board Member. American Journal of Psychiatry 133:1200-1202, 1976
63. Sharfstein SS: Third Party Payers: To Pay or Not to Pay. American Journal of Psychiatry 135:1185-1188, 1978
64. Zusman J, Lamb HR: In Defense of Community Mental Health. American Journal of Psychiatry 134:887-890, 1977
65. Sabshin M: Community Psychiatry: Slogan or New Directions, in Controversy in Psychiatry. Edited by Brady JP, Brodie HKH. Philadelphia, Pa, W.B. Saunders, 1978
66. Peterson LG: On Being A Necessary Evil at a Mental Health Center. Hospital and Community Psychiatry 32: 644, 1981

A Survey of CMHC Psychiatrists Regarding Their Perceived Need for a National Association

Presented at the Institute on Hospital and Community Psychiatry, Montreal, Canada, October 13-17, 1985, and at the Annual Meeting of the National Council of Community Mental Health Centers, Las Vegas, Nevada, April 2-5, 1986.

In an effort to answer the question, "Is there a need for a National Association of CMHC Psychiatrists?", a national survey of CMHC psychiatrists was conducted. There were 300 respondents. 93.3% indicated that such an association is a good idea, 3% felt that it is not, 2.6% were uncertain, and 1% gave no response. While the questionnaire asked for the name of the CMHC medical director, 21.3% of respondents were unable to supply such information. It appears from the data gathered in this survey that a significant proportion of CMHC psychiatrists are employed part-time. Finally, less than 10% of respondents indicated that a state association for CMHC psychiatrists exists in their area. Representative comments that accompanied these responses are shared.

Introduction

While much has been written about the multiple pressures that CMHC psychiatrists experience and that ultimately cause many of them to leave community mental health, there has been no ongoing national organization devoted to CMHC psychiatrists within which they could find both mutual support and a political base for effective action. In the early years of the CMHC movement, the "American Association of Community Clinic and Center Psychiatrists" was formed, but this organization has been inactive for a number of years. However, concerns continue regarding the ongoing exodus of psychiatrists from CMHCs and apparently concomitant deterioration in quality of care. The report of the American Psychiatric Association's Task Force on Community Mental Health Programs reflects this concern: "the downward trend, characterized as the 'flight of psychiatrists from CMHCs' has been deleterious to the quality of mental health care in such centers."[1]

Method

In that a national association might be helpful to this seemingly beleagured group of psychiatrists, and might additionally shore up quality of care within CMHCs, a questionnaire was distributed to 2158 psychiatrists within the APA directory who had expressed an interest in community mental health. 13.1% (283) of the questionnaires were returned, including one from Canada and one from Switzerland. A letter to the editor of "Psychiatric News," which consisted of both the cover letter and questionnaire that were distributed in the above mailing, generated an additional 17 responses by letter, for a total of 300 responses.

The survey inquired about the following: 1) "Do you think a national association for psychiatrists in CMHCs is a good idea?"; 2) "Name of your Medical Director"; 3) "Names of the psychiatrists who work in your CMHC, designating their full-time equivalent percentage"; 4) Name and address of any state association for CMHC psychiatrists."

Results

To the question, "Do you think a national association for psychiatrists in CMHCs is a good idea?", 93.3% of the 300 respondents replied positively, 3% negatively, 2.6% equivocally, and 1% gave no response. The following are some of the comments which accompanied these responses. An attempt was made to represent all points of view. Where comments were similar, one or several representative comments are reported. Some of these are edited.

In the negative:

"Like the APA, it seems a useless organization."

"Too many associations, too many dues, too little time."

Several respondents were equivocal. One of these writes, "I support, in principle, the formation of a national group. I think that our statewide effort should first be supported."

Among the respondents who replied affirmatively, one expressed the concern that, "Many use part-time psychiatrists who would be difficult to organize." Other affirmative responses are as follows.

"The agency does not currently have a medical director since I left the organization 2½ years ago. I am still keenly interested in community mental health and feel strongly that a national association for psychiatrists interested in community mental health would be most desirable."

"I am a newly appointed medical director and it is apparent to me that there is an amount of professional isolation inherent in this position. Our centers are by definition geographically distant from one another. Even though there may be other psychiatrists involved in our centers, it is not easy to establish dialogue with others in similar medical-administrative positions. I believe the organization you are suggesting may well provide such a service."

"I feel it is an excellent idea for us to 'get organized' and begin to have some meetings. From my experience in organized psychiatry it is best to keep any dues as low as possible." "Attempting to transact as much of the business, and conduct as many of the meetings as possible concurrent with the annual APA convention or the Institute on Hospital and Community Psychiatry would be preferable to separate meeting times."

"Wonderful! I developed a number of very serious questions regarding the active harm done patients in these centers as a result of shoddy, sloppy, inept practices prompted by careless, uninformed administrative decision making and fostered by staff burnout and minimal resources. My interests still strongly lie in improving this shamefully decrepit, often corrupt, system."

"It is long overdue!"

"And very necessary."

"Receipt of your letter was very timely in that we are being asked to do very much what you described, i.e., 'to give more for less and to take more medico-legal responsibility without commensurate authority'. Hope this organization is successful in getting started and in helping to reverse the trends you aptly described."

"Urgently needed if CMHC lay boards are to be influenced toward use of the psychiatrist's mental health knowledge. I am no longer associated with a CMHC. Unfortunately, that organization has now hired a 'less expensive' psychiatrist who is completing his residency training."

"I resigned in 1983 after working with the CMHC and its preceding Guidance Clinic since 1957. Got fed up. The regular staff gets a 5% raise every year. The consultants have had no raise since 1972. The CMHC was clearing a profit from my services and the director implied he could hire foreign trained psychiatrists cheaper."

"Frequently CMHCs carry a lower status along with a lower income. An association might be able to emphasize the skills necessary to practice in CMHCs."

"Yes, because of the progressive loss of power of psychiatrists in every aspect of programming and implementation."

"Our position and profession is underestimated, underappreciated and underpaid."

"The lack of psychiatrists in CMHCs is partially that their skills are not understood and appreciated. Some are being replaced by G.P.s and psychologists. Maybe psychiatry is an endangered species. We badly need standards compatible with the aims of psychiatric practice. There is not ample time allotted for a psychiatrist to supervise staff or see patients. The malpractice risk is very great and I do not want it."

"The CMHC does more harm than good and is based on dishonesty, greed, and empire building with the goal being to keep the staff employed at all cost to taxpayers and patients. For legal reasons I'm advised by APA attorneys to consult only but not to supervise. I see 200 potential malpractice suits plus regular defrauding of insurance companies with false claims of supervision by an Ed.D. psychologist. All of this serves to increase the cost of medical care and give psychiatry a bad name. If your group can help to change this deplorable situation, I'm interested."

"Your letter touched on some issues which led our most recent medical director to leave. I hope that you get a good response for such an organization since I think it would be useful."

"After seven years battling the pressures of responsibility 'sans' authority, I have abandoned ship along with so many others, and entered the more gratifying arena of private practice."

"I struggle daily with the issues mentioned in your letter; these are so serious at one of the centers where I am employed, that it is only a matter of time before I leave. I only hope it is possible to try to reverse trends that I fear are already so entrenched that they may be intractible."

"Although I was able to put up with the atrocious working conditions, low pay, and lack of resources in my clinic, I was unable to accept direct interference in the doctor/patient relationship that infringed on my authority as a

doctor. I had come to have great affection for the people and neighborhood and had invested a great deal in this clinic even though my work there was part-time. The decision to resign was a painful one and support or assistance with this decision from a national association would have been welcome."

Alternatively:

"In the early days of community psychiatry, all interested physicians belonged to the Mental Health section of the American Public Health Association. I believe it might be appropriate to return now to the general field of public health."

"I think it would be better to have a function-focused organization, i.e., Association for Collaborative Psychiatry."

"I would broaden it to include government agencies (State Hospitals)."

Regarding the American Psychiatric Association:

"What can be done to get an APA committee on CMHCs? Private practice, general and state hospitals have committees, but CMHCs don't to my knowledge."

"The APA has shown little regard for the plight of CMHC psychiatrists and the conditions under which they work."

Regarding financial constraints and the difficulty of affording membership dues and association meetings:

"Can't afford it! I work in a CMHC."

"While my last employer provided educational leave with expenses annually, my present center's budget is so constrained that educational leave is moot and expenses out of the question."

Asked to provide the "Name of your Medical Director," 78.7% of the respondents did so. However, 13.3% reported that there was none, 2.7% responded that there was none now, and 5.3% left the space blank. Respondents indicated that the Medical Director position was filled in 3 cases by a Ph.D., in 3 cases by an M.S.W., and in 2 cases by a Mrs. and a Ms. The breakdown by state of these responses which failed to produce the name of the center's Medical Director is outlined in Table 1. Twenty-seven states plus the District of Columbia and British Columbia, Canada are represented on this list.

Table 1:

Responses by state to, "Name of your Medical Director":

	None	None now	No response
Arkansas			X
California	XX	X	XXXX
Connecticut	X		
Florida	XX	X	
Georgia	X		
Illinois	XXX		
Iowa			X
Kentucky		X	
Louisiana	X		X
Maine	XX		
Maryland	XX		X
Massachusetts			X
Michigan			X
Minnesota	XX		
New York	XXX		XX
North Carolina	X	X	
Ohio	XX		XX
Oklahoma			X
Oregon	XX	X	
Pennsylvania	XX		X
South Carolina	X		
Texas	XX		
Vermont	X	XX	
Virginia	XXX		
Washington	X		X
Washington, DC	XX		
West Virginia	X		
Wisconsin	XX	X	
Vancouver, BC	X		
	40	8	16

Among comments in this section are the following:

"None, and probably needed!"
"Myself, until I resigned. None now."
"None at any of these centers. Each center employs consultant psychiatrists only, each for a maximum of 6 hours/week."
"None, title abolished."
"None (position filled by an administrator who is a social worker)."

In response to the request for "Names of the psychiatrists who work in your CMHC, designating their full-time equivalent percentage," 51.6% (155) of the respondents supplied reasonably complete data. Where respondents supplied full-time equivalency (FTE) percentages on all psychiatric staff except their medical director or themselves, it was assumed that each represented 1 FTE. This may skew the results in the direction of a best case scenario with more FTE psychiatrists represented by this data than are actually practicing in these centers. In any event, the total number of psychiatrists practicing in these centers should be quite accurate.

There are 662 psychiatrists practicing in these 155 centers. Of these, 42.3% were designated or judged to be full-time. The remainder, 57.7% were designated by the respondents to be part-time; the FTE breakdown of these part-timers is outlined in Table 2.

Table 2:

Percentages of full-time equivalency (FTE) for the total of 382 part-time psychiatrists in 155 CMHCs:

1% — 24% FTE: 35% of part-timers
25% — 49% FTE: 27% of part-timers
50% — 74% FTE: 28% of part-timers
75% — 99% FTE: 10% of part-timers

In 18 (11.6%) of the 155 centers, there are reportedly no psychiatrists who practice at least half-time. One respondent reported that at the CMHC near him, there are "No psychiatrists."

The final section asked for the "Name and address of any state association for CMHC psychiatrists," to which only 8.7% responded that some sort of a committee or association had existed, does exist, or is about to be formed. These results are detailed in Table 3.

Table 3:

Summary of responses to "Name and address of any state association for CMHC psychiatrists."

States with active committes for CMHC psychiatrists:	New Hampshire North Carolina Oregon Pennsylvania Vermont
States for which respondents differed as to whether committees do or do not exist:	Massachusetts Ohio Washington
State with an inactive committee:	Florida
States with some internal regional groups:	California Ohio (cf. above)
State with an interdisciplinary CMHC group:	New York
States in which respondents are planning to start a group:	Arkansas Maine

It appears that there are only a handful of states that have some form of committee for CMHC psychiatrists and their issues. The respondent from Vancouver, B.C. reported, "No provincial organization and no national organization." The Swiss respondent reported that they had an interdisciplinary national association of community mental health professionals.

Discussion

According to Beth Prester, Circulation Director of the American Psychiatric Association, the 13.1% response rate was "very good" considering that the APA directory information was several years old and considering that "list mortality" is generally considered to be 25% per year (personal communication). Taking these factors into account raises significantly the response rate on the part of those who actually received the questionnaire. Caution must be exercised, however, in

projecting these results to the ideal target population of all CMHC psychiatrists in the United States. Nevertheless, among those who did respond to the survey, there was overwhelming support for the formation of a national association for CMHC psychiatrists. Some concerns that were raised bear further discussion.

With regard to the suggestion that the development of "another splinter association" be avoided in favor of working through existing organizations, Donald Hammersley, M.D., Deputy Medical Director of the American Psychiatric Association, holds the opposite point of view. In essence, he believes 1) that a separate organization can act more rapidly than a large, slow moving organization such as the APA, and 2) that a separate organization can speak with its own voice, and not be dependent upon the assent of a board of trustees of a large organization serving many diverse interests (personal communication). Additionally, a separate organization can press upon other organizations to gain collective support for its positions.

Regarding the suggestion that a "statewide effort should first be supported," clearly any national association must recognize and support the need to organize locally, either by state or by APA District Branch. Such grassroots networking provides both vital colleaguial support and a base from which local political realities may be addressed.

The suggestion that dues of an organization be kept as low as possible should be attended to for two reasons. Firstly, CMHC psychiatrists are among the lowest paid in their profession. Secondly, having the largest number of members possible in such an association is vital to the organization's survival and effectiveness.

Having meetings that run concurrently with other psychiatric meetings, as one respondent suggested, also enhances participation. According to another respondent, some CMHC psychiatrists suffer from having little, if any, conference time or funding provided by their centers for continuing medical education. The value of doubling up on meetings is evident.

With respect to the idea that it would be better to have a "function-focused organization, i.e., Association for Collaborative Psychiatry," such an organization already exists: the American Orthopsychiatric Association. However, such a large organization, with membership representation by all the mental health disciplines, cannot adequately address the specific concerns of CMHC psychiatrists.

The suggestion to broaden the focus of the association "to include . . . State Hospitals" similarly risks diluting sorely needed corrective action which must be targeted expeditiously on CMHCs. Once such a mission has been successfully accomplished, broadening the scope of such an association to "Public Psychiatry" might be very worthwhile.

While the criticism that the "APA has shown little regard for the plight of (CMHC) psychiatrists" may seem valid, as there is no standing component within the APA devoted to community psychiatry, the fault for this probably rests as much with CMHC psychiatrists as with the APA. John Talbott, M.D., recent president of the APA, aptly pointed out that the APA does not simply do for its members, but rather assists them in doing for themselves (personal communication). While it is recognized that CMHC psychiatrists are under tremendous time and financial constraints, they must take the time to get politically involved, as, for example, in their District Branches. In defense of the APA, it does have an active Assembly Task Force on Psychiatric Roles in Community Mental Health Centers. Furthermore, the APA has published jointly with the National Council of Community Mental Health Centers an important monograph entitled, "Community Mental Health Centers and Psychiatrists."[2]

In the center in which there is no medical director and only "consultant psychiatrists" who are employed for a "maximum 6 hours/week," one might wonder about possible deliberate efforts to minimize and neutralize medical involvement in some settings.

According to Table 2, the majority of the CMHC psychiatrists from whom responses were received practice part-time. Further, the majority of part-timers practice less than half-time in the CMHC. Of even greater concern is the fact that 11.6% of the 155 centers represented by this table have no psychiatrists who practice at least half-time. Beigel has suggested that the role of part-time psychiatrists is different from that of full-time psychiatrists.[3] It could well be that such a difference in role is reflected in the quality of patient care. Indeed, one might well wonder how much of a role, if any, such part-time psychiatrists could have in such critical oversight functions as clinical supervision, program planning, and quality assurance. Where one respondent reported that there was no psychiatrist at a CMHC near him, this is a situation which is certainly cause for serious concern.

There are no good data as to the number or identification of psychiatrists practicing in CMHCs across the country. Extrapolating from the results of this study (662 full and part-time psychiatrists practicing in 155 centers), in combination with data from the National Council of Community Mental Health Centers (1,572 agencies nationwide),[4] there are approximately 6,714 psychiatrists practicing in U.S. CMHCs.

Table 3 points out the paucity of statewide organizations for CMHC psychiatrists. Even in those states in which some organization exists, knowledge of its existence may be very limited. Given the daily struggles of many CMHC psychiatrists, meeting monthly with colleagues undergoing similar struggles can provide opportunities for both mutual support and constructive action.

On a final note, the affect contained within many of the respondents' comments is striking. At the heart of this affect seems to be a pervasive feeling on the part of the respondents that their position of medico-legal responsibility is abused by

the CMHC. Their signatures are used, but their expertise is ignored. The quality of their training, experience, and patient care seem not to be valued. Residents are preferred over Board certified psychiatrists because they are less costly. It is also easier to take advantage of residents who have embryonic psychiatric identities and who may unwittingly assume substantial medico-legal responsibility without commensurate authority. Once they become aware of this misalignment or feel mistreated in other ways, they, too, may flee the trenches of community mental health for greener pastures. Sadly, patients are the real casualties in these situations, for they have no choice but to remain in these trenches, inadequately treated.

Conclusion

Many psychiatrists find it increasingly difficult to work in CMHCs. Indeed, many psychiatrists have left CMHCs in favor of positions that are more professionally and personally rewarding. The questionnaire described in this paper was developed to explore the possibility that those psychiatrists who remain in community mental health might find a national association useful. Such a national association could provide both a sorely needed support network and a political base to impact constructively upon CMHCs. Further possible benefits of such an association include the opportunity more systematically to explore issues of special concern to CMHC psychiatrists, such as the training of medical students and residents in community mental health, and recruitment and retention of CMHC psychiatrists.

As a result of the considerable support for and perceived need of a national association, the American Association of Community Psychiatrists was formed at an organizational meeting in Denver, Colorado on October 14, 1984.

References

1. American Psychiatric Association: Report of the Task Force on Community Mental Health Programs. American Journal of Psychiatry 139:705-708, 1982
2. Joint Steering Committee of the American Psychiatric Association and the National Council of Community Mental Health Centers: Community Mental Health Centers and Psychiatrists. Washington, DC and Rockville, Md, American Psychiatric Association and National Council of Community Mental Health Centers, 1985
3. Beigel A: The Remedicalization of Community Mental Health. Hospital and Community Psychiatry 35:1114-1117, 1984
4. Knox MD: National Registry Reveals Profile of Service Provider. National Council News, September, p. 1, 1985

Quality Care at Risk in CMHCs: A Need for Standards of Psychiatric Practice

Presented at Annual Meeting of the American Psychiatric Association, Washington, D.C., May 10-16, 1986.

Abstract

The author discusses the frequent and serious concerns that have been expressed regarding the inadequate attention paid to quality of care in many CMHCs. He suggests that the apparent deterioration of quality care in many centers is related to the exodus of competent psychiatrists from those centers. Efforts of JCAH to develop standards by which to accredit CMHCs are discussed. The issue of cost as a function of quality care is raised. Finally, the author highlights key points which he proposes for inclusion in "Standards of Psychiatric Practice for CMHCs". Such "Standards", he suggests, would assure that quality care is delivered in a cost-effective manner. He proposes that such "Standards" ultimately be incorporated into JCAH's accrediting standards for CMHCs, and that governmental and other third-party reimbursement be tied to JCAH accreditation.

CMHCs and Quality of Care: A Review of the Problem

According to a 1983 report of the Group for the Advancement of Psychiatry, "For the most part CMHCs are not taking adequate care of the seriously and chronically mentally-ill patients."[1] Freedman writes that, "There are pressing real issues concerning quality of care."[2] Arce and Vergare also write, "the patients seen at CMHCs are receiving increasingly less sophisticated psychiatric care."[3] According to Perr, "Clearly, over a period of years, the public sector has been deteriorating in terms of quality and quantity of health care delivery."[4]

Aside from such concern regarding the deteriorating quality of care in CMHCs, many have expressed concern, undoubtedly related, regarding the changing role of psychiatrists in these centers. Leong, for example, writes, "In the intervening years (since the Community Mental Health Centers Act was signed into law by Kennedy) the role of the psychiatrist in these centers has changed so much that in many cases the only alternative to ignominy is for competent, conscientious psychiatrists to totally withdraw their services and support from them."[5] Concern has even been expressed regarding the possible "active harm" done patients in some CMHCs (Clark GH: CMHCs and Psychiatrists: A Necessarily Polemical Review. Submitted for publication, 1987. See pages 5-21 of this monograph). Phillips unequivocally states, "Something must be done to improve the psychiatric care in these centers or psychiatrists must dissociate from them."[6] Talbott points out that, "Constraints on the psychiatrist's ability to achieve what he wants to achieve in improving patient care and upgrading the system are important reasons why some leave the public sector."[7] While the withdrawal of the competent, conscientious psychiatrist, who refuses to collude with a system that delivers poor quality care, solves a personal dilemma, it may well contribute to the overall deterioration in the CMHC's Quality of care. This is for two reasons: 1) vacancies in problematic systems often remain unfilled; and, 2) when such vacancies are filled, they may be occupied by psychiatrists who may not be as well trained and/or as adherent to high clinical standards.

Koran states that, "Institutional vacancies are undoubtedly affecting the quality of care."[8] Aside from vacancies, the proportion of psychiatrists to all community mental health center staff dropped by 36% between 1970 and 1977, according to NIMH data.[9] Arce and Vergare express concern about such a reduction in the ratio of psychiatrists to patient population and about the resultant adverse impact upon quality of care.[3] Langsley warns that, "Some centers have dangerously few psychiatrists."[10]

Aside from there now being relatively fewer psychiatrists in CMHCs compared with other staff, Diamond et al report that there is concern about the quality of psychiatric input. They note that many centers are now staffed by part-time physicians, many of whom were trained in foreign medical schools.[11] Perr additionally notes that psychiatric foreign medical graduates have become concentrated in the public sector.[4]

Making matters worse, because a number of residency training programs question the compatibility of CMHC goals with quality psychiatric education, and because, therefore, a number of training programs have terminated relationships with CMHCs,[12] the difficulty attracting young, well trained psychiatrists to CMHCs is even greater. Trainees are unlikely to choose community psychiatry as a career without having had a positive experience in such a setting. They are even less likely to do so if they have had no exposure whatsoever to a CMHC during residency training.

Langsley and Barter contend that cost, not quality, determines staffing decisions in CMHCs.[13] However, they point out that, "adequate psychiatric staffing is absolutely essential to quality mental health services . . . There are certain medical-psychiatric skills that only the psychiatrist possesses, and such skills cannot be obtained from a less expensive staff member."[13] Attempts to short-circuit appropriate involvement of a competent psychiatrist may result in inaccurate diagnosis and, consequently, inappropriate treatment. This in turn results in both poor quality care and ultimately greater cost to the entire system, as patients who are inadequately treated at the local level often end up requiring local or even state hospitalization.

According to Fink and Weinstein, "Deprofessionalization has led to a decline in the number of psychiatrists in community mental health centers and a potentially negative impact on the quality of patient care."[14] They add that this deprofessionalization "appears to be a repetition of the situation that developed in the state hospital system earlier in this century, when the quality of patient care deteriorated, professional involvement was reduced or eliminated, and the hospitals became repositories for the poor." Boyts, a past-president of the National Council of Community Mental Health Centers and a social worker, has also expressed the concern that CMHCs are at risk for going the way of many state hospitals (personal communication). Lehman and Lehman warn that, "If we decide to accept lower ratios of psychiatrists than previously envisioned, we risk replicating the very state mental hospital system CMHCs were supposed to supersede."[15] This would be most unfortunate for, as Zusman and Lamb indicate, community treatment of the severely and chronically mentally ill is the "raison d'être" of community mental health, and, in fact, it was originally concern over the abysmal conditions of treatment and life for patients in state hospitals that prompted the CMHC movement.[16]

Sabshin writes, "The number of first-rate assessments of the quality of care in centers is much too limited."[17] According to Cohen and Stricker, the quality assurance programs of CMHCs have "de-emphasized the role of psychiatric diagnosis and have instead emphasized such issues as the client's level of functioning."[18] The risk of such an approach, of course, is that treatment aimed strictly at symptoms without regard for the underlying diagnostic condition is an entirely hit or miss proposition. Just as one cannot make a treatment decision based on the presence or absence of a fever, so one cannot make reasonable treatment decisions based simply upon abnormal behavior, mood, or thoughts. Fever, like abnormal functioning in these other areas, can be due to a myriad of causes; appropriate and effective treatment must first address itself to the underlying cause of the symptom. The psychiatrist is the only mental health professional that can make a comprehensive bio-psycho-social diagnosis. Further, he is the only mental health professional that can medically treat the seriously mentally ill. Unless the patient is provided a stable biological foundation through accurate diagnosis and appropriate medical treatment, all other psychological, social, and rehabilitative treatment efforts are for naught. Abroms adroitly articulates this point in his article, "Beyond Eclecticism."[19]

Unfortunately, in many CMHCs today, the expertise of psychiatrists is not appropriately utilized. The situation has become so deplorable in some centers, according to Diamond et al, that psychiatrists are used solely for "signing prescriptions and insurance forms, often for patients they have not seen or evaluated personally."[11] Arce and Vergare point out that such situations generate serious questions of fraud.[3] Third-party payers assume, often fallaciously, that the psychiatrist's signature means that he is responsible for and in charge of the treatment. But in all too many instances the clinician supposedly operating under the supervision of the psychiatrist as a "physician extender" has become a would-be "physician replacer."[3] A gross example of this, as described in the "Report of the Task Force on Community Mental Health Programs" of the American Psychiatric Association, is that some psychiatrists have been pressured to sign blank prescriptions which are later filled in by nurses.[20] Such inappropriate and even illegal and unethical use of psychiatrists must be stopped if CMHCs are to remain viable institutions for the treatment of the seriously mentally ill.

Borus observes that community mental health has been criticized as 'second-class psychiatry', substituting quantity for quality care. He goes on to say that the essence of 'first-class psychiatry' is careful, expert oversight by the most experienced clinicians, usually psychiatrists, in order to assure that each patient's problem is correctly evaluated and that a differentiated therapeutic response is made to fit that particular problem.[21] Supporting such a vital oversight role, Berlin et al write, "Among CMHC staff, only the psychiatrist has been extensively trained to integrate clinical data based on the social, psychological, behavioral, and biomedical models."[9]

Regretably, and leading to the departure of many psychiatrists from CMHCs, Talbott observes that, "the awesome responsibility to provide care and treatment for the most severely and chronically mentally ill is not accompanied by the authority to do the job."[7] A number of authors advocate that the psychiatrist be granted authority commensurate with the medico-legal responsibility he holds.[16,22-24] The American Psychiatric Association, in its "Position Statement on Community Mental Health Centers," states that, "The medical, including psychiatric, treatment program offered by a community mental health center must be the responsibility of a physician, preferably a psychiatrist, and should be directed by him."[25] Other authors also stress the importance of the psychiatrist's being in a team leadership role.[5,26] Okin emphasizes that, especially in the wake of deinstitutionalization with CMHCs' having increased responsibility for the seriously mentally ill, psychiatrists are becoming increasingly critical to the success of the community mental health system.[27]

Du Mas, a psychologist, predicted back in 1974 that CMHCs would, after passing through non-medical and then anti-medical models, return to a medical model of patient care: "In the long run this transition should be good for medical and nonmedical mental health practitioners as well as the general public, and out of these uncomfortable adjustments will come a better program of community health care."[28] Astrachan maintains that, "the future of health care organizations lies primarily in their members' clinical competency and commitment to excellent practice."[29] Assuring that CMHCs practice at the community standard for psychiatric care will help to asssure their future in the health care delivery system. Anything short of this will put their patients' well-being and their own long range viability at risk.

The Need for Standards in CMHCs

As long ago as 1968, Kubie called upon community psychiatry to "spell out in detail the plans for . . . accrediting."[30] Yet this issue has remained inadequately attended to, and so Farkas writes years later, "One of the major criticisms leveled against the CMHC program has been a lack of monitoring and evaluating the clinical care rendered by the centers."[31] Osberg and Johnson report that in a review by the North Carolina Division of Mental Health and Mental Retardation Services of the 43 area mental health programs, the lack of sufficient, qualified clinicians, especially psychiatrists, for direct care and clinical supervision was commonly cited.[32] Efforts aimed at redressing these shortages have led North Carolina to be among the most progressive states in developing strategies to recruit and retain competent CMHC psychiatrists. While North Carolina's CMHC psychiatrists continue to face serious problems, they have been very active in their efforts to find solutions. They developed a comprehensive position paper, adopted by the North Carolina Neuropsychiatric Association, entitled "Community Mental Health Center Psychiatry."[33] As part of their recommended "Steps to prevent further deterioration of patient care," they call for both "a clear definition of the psychiatrist's role" and "the formulation of appropriate standards of psychiatric practice in CMHCs . . . standards for care comparable to those in any good medical care facility." The Group for the Advancement of Psychiatry advocates that, "Psychiatrists ought to be involved in the planning, implementation, and monitoring of all programs to prevent the blurring of programmatic focus and the lines of professional responsibility."[1] Sharfstein writes, "Standards . . . must be developed so that there is a system of accountability."[34]

The North Carolina position paper goes on to say the following:

> *"Each community program must have a psychiatrist as medical director with the overall and ultimate responsibility and administrative authority for treatment and care of all patients. He/she must have direct access to the governing body — perhaps along the lines that hospitals have used — governance jointly by medical staff and hospital administration. (Also), any given psychiatrist can only be responsible for a finite number of patients."*[33]

Beigel et al amplify upon this last point, suggesting that staffing standards, which include appropriate ratios of psychiatrists to the other clinical staff, be a condition of funding.[35] Langsley and Barter believe that the government, in general, and the National Institute of Mental Health, in particular, should take the responsibility for establishing staffing standards mandating an appropriate role for the CMHC psychiatrist and requiring care comparable to that provided in the private sector.[36]

CMHC Standards and JCAH

While the CMHC Amendments of 1970 required states to develop standards for centers, this provision, according to Windle and Ochberg, was not rigorously enforced by the federal government. NIMH subsequently contracted with the Joint Commission on Accreditation for Hospitals to develop standards for CMHCs. These standards were anticipated to upgrade the quality of care in CMHCs and provide guidelines for federal reimbursement.[37] However, according to Faulkner et al, even efforts by JCAH to develop a system of uniformly acceptable standards have not been successful, predominantly because little relationship exists between JCAH's accreditation process and fiscal rewards for CMHCs.[38]

In 1976, JCAH produced the "Principles for Accreditation of Community Mental Health Service Programs." According to Mcaninch et al, these "Principles were based on the 'balanced service system' concept and introduced a model and a sociological language that were new to most mental health professionals."[39] Three factors apparently contributed to the non-medical tone of the CMHC "Principles." Firstly, they were based upon the work of a masters level psychologist and a masters level social worker. Secondly, the JCAH Task Force that drafted these standards was composed of three non-psychiatrists and two psychiatrists. Already in the minority, these two psychiatrists magnanimously supported an egalitarian approach rather than holding to a more traditionally hierarchical, medical model. Thirdly, the Board of JCAH, having accomplished the monumental task during the previous two years of developing the Accreditation Manuals for Child and Adolescent Psychiatric Facilities, Alcohol Abuse Programs, and Drug Abuse Services, gave only perfunctory review of the CMHC "Principles" (Mcaninch M: personal communication). The focus of these "Principles" on multidisciplinary practice may well have served to exacerbate already fomenting conflicts regarding such issues as appropriate roles, clinical responsibility and authority, accountability, etc., and, thus contributed to the already mounting exodus of competent psychiatrists from CMHCs. Langsley has expressed concern regarding the "antimedical bias" of these "Principles."[40] Astrachan elucidates, "many of us viewed the JCAH CMHC Standards as an invitation to bad care, to care which viewed hospitalization as restriction of liberty, and not as needed treatment — and which viewed the work of psychiatrists as requiring tight administrative supervision and not the process of peer review" (Astrachan B: Discussant response at the symposium, "Quality Care at Risk in Some Psychiatric Settings," American Psychiatric Association annual meeting, 1986).

JCAH is currently in process of folding the standards for CMHCs into its "Consolidated Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Programs," originally developed in 1979. According to Mcaninch (personal communication), under these revised standards, the relationship of the governing body to the professional staff organization will be emphasized with particular regard to privileging and quality assurance. Staff will be privileged to provide services only in those areas in which they are determined to be competent. Ongoing monitoring and evaluation of the appropriateness and quality of patient care by all disciplines and ancillary staff will be required. Such revisions regarding organizational relationships and accountability may go a long way toward redressing the problems that many CMHCs are currently experiencing. Vuori, referencing a number of other authors, points out that one of the most effective ways to correct qualitative deficiencies is by means of organizational and administrative changes.[41] As to the psychiatrist's place within the organization, Maguire notes that, "hierarchies in hospitals tend to be more clearly defined than in community mental health centers."[42] The American Psychiatric Association's "Report of the Task Force on Community Mental Health Programs' advocates the following: "We strongly recommend that community mental health programs have privileges and credentials committees that screen all professional staff, recommending acceptance for specific therapeutic modalities based on those individual qualifications."[20] With CMHCs being held increasingly accountable, both medico-legally and fiscally, they may well opt, ultimately, for being structured and operated more like hospitals. Aside from enhancing quality of care, this would, by tying clinical responsibility to authority, do much to relieve the role strain experienced by many CMHC psychiatrists.

Despite these positive changes, the "Consolidated Standards" do have their own deficiencies. Astrachan went on to say, in the above noted symposium, that, "The APA Committee on Hospital Based Standards and a majority of our members have viewed (the 'Consolidated Standards') as denigrating medical responsibility and as overly prescriptive." Continued refinement of the "Consolidated Standards" will clearly be needed beyond the current process of incorporating the community mental health "Principles."

Cost Containment and Quality of Care

As Kopolow aptly observes, "The government wants the best quality of care and treatment for its citizens at minimal cost."[43] Mattson notes that, "there is increasing focus in the literature on cost containment as an integrated part of quality assurance."[44] It has been customary for industry, according to Vuori, to use such a functional definition of quality: "quality is the capability of a product to fulfill its intended purpose of use, produced with the least possible costs."[41]

Referencing Helfer, Vuori suggests that the quality of health care can be measured by means of three concepts: proficiency, which indicates whether all that is deemed necessary for good care is done; efficiency, which indicates whether all that was done was necessary; and competency, which is a combined measure of these two.[41] Failure to perform with proficiency may well result in negligence or malpractice litigation. Failure to perform with efficiency drives up costs. Either of these alone or in combination can put a system out of business. Shervert Frazier, the recent Director of the National Institute of Mental Health, reported to the National Council of CMHCs at its 1986 annual meeting that some form of "capitation" on reimbursement for outpatient care is near at hand. If CMHCs are effectively to negotiate today's rough waters of risk management and cost containment, they will require competent psychiatrists at their clinical helms.

Proposed Standards of Psychiatric Practice for CMHCs

Because clinical authority has not been adequately tied to the medico-legal responsibility held by CMHC psychiatrists, and because, therefore, many psychiatrists continue to have great difficulty assuring quality of care within their systems, I originally drafted a preliminary set of "Standards of Psychiatric Practice in CMHCs" for an Ad Hoc Committee of the New Hampshire Psychiatric Society. The process of developing these "Standards" is ongoing. In an effort to solicit national input into this process, a draft of these "Standards" was recently published in "Community Psychiatrist."[45] Highlights of the latest revision of these standards are described below.*

*The author gratefully acknowledges the invaluable input of the following groups and individuals into the drafting and revising of these standards: the Ad Hoc Committee to Develop Standards of Psychiatric Practice for CMHCs; its parent committee, the Committee of Psychiatrists in New Hampshire CMHCs, a standing committee of the New Hampshire Psychiatric Society: the Council of the New Hampshire Psychiatric Society; the Board of the American Association of Community Psychiatrists; the Ad Hoc Task Force on CMHC Psychiatry of the National Council of Community Mental Health Centers; the Task Force on Professional Practice Issues in Organized/Managed Care Settings of the American Psychiatric Association; and, especially, Zlatko Kuftinec, M.D., Don Brada, M.D., Hal Boyts, M.S.W., and Harout Babigian, M.D.

These psychiatric standards of practice begin with a comprehensive rationale for the psychiatrist's being in the preeminent, clinical role. Ultimate medical/clinical responsibility and authority for patient care must rest with a psychiatric Medical Director for the following reasons: 1) with the responsibility for treating the seriously mentally ill increasingly resting on CMHCs, they must become true health care facilities; 2) comprehensive bio-psycho-social diagnosis and treatment is essential for this patient population; 3) psychiatrists are the only mental health professionals with the medical training and expertise required to evaluate physical problems as well as their relationship to psychological and sociological phenomena; 4) medical problems that are potentially life-threatening frequently present as psychiatric problems and require prompt diagnosis and treatment; 5) the mentally ill frequently have other, concurrent medical problems; and 6) treating this patient population usually requires the prescribing of medication or other somatic therapies, which, in turn, often require careful physical and physiological preparatory workup and continued monitoring for side effects and toxicities.

The cornerstone of these standards is a model job description for the CMHC Medical Director which ties medico-legal responsibility to commensurate authority. Key elements of this job description are that the Medical Director: 1) has ultimate responsibility and authority for the medical/clinical services of the center; 2) is responsible for assuring that all clinical staff are appropriately privileged and supervised; 3) is responsible for assessing the quality of care delivered; 4) serves as a member of the center's board of directors; 5) is certified by the American Board of Psychiatry and Neurology.

According to the standards for psychiatric staffing of CMHCs, there should be a minimum of one full-time equivalent (FTE) psychiatrist per 20,000 catchment population, and there should be a minimum of one FTE psychiatrist per 10 other clinical staff. These figures represent the consensus of the Committee of Psychiatrists in Hew Hampshire CMHCs. It is recognized that a greater density of seriously mentally ill patients within a given catchment area, as in more urban areas, necessarily dictates an upward adjustment of these minimums.

According to the emergency service standards, a psychiatrist must be available at all times for telephone consultation with staff and for direct evaluation of emergency patients. Also, all patients that present on the emergency service are to be reviewed with a psychiatrist during the next working day.

The standards for psychiatric responsibilities on a mustidisciplinary team mandate that each clinican have one individually scheduled hour per week with a psychiatrist for the joint management of patients. Such meetings serve four important functions: 1) they provide assurance that services provided as health care meet prevailing medical standards; 2) they provide regular opportunities for collaboration on patients whom the psychiatrist and clinician have in common; 3) they provide opportunities to educate the staff regarding the interrelationship of psychosocial and physiological problems, as well as the appropriate use of psychotropic medications, their side effects, toxicities, etc.; and 4) they provide a supportive, anti-burnout function by sharing responsibility for and expertise in dealing with severely disturbed patients.

The standards for the psychiatric evaluation and treatment of patients require that the cases of all new patients be seen or reviewed by a psychiatrist who will decide whether futher psychiatric or other medical evaluation is needed. All patients requiring medication must be directly evaluated by a psychiatrist before starting, and they should be monitored by a pychiatrist at clinically appropriate intervals; once every three months should generally be the outside limit.

Because of the not infrequent abuse of psychiatric signatures within CMHCs, standards are clearly needed in this area as well. The psychiatrist should write or telephone in prescriptions only for patients with recent psychiatric evaluations. All diagnostic formulations and treatment plans must be reviewed and signed by a psychiatrist before implementation. The psychiatrist should sign-off on insurance or other forms only on those patients with whom he has appropriate clinical knowledge.

The Council of the New Hampshire Psychiatric Society advocates that the psychiatrist sign the diagnostic formulations and treatment plans only on those patients with whom he has had direct clinical contact. The North Carolina Neuropsychiatric Association goes even further in its position paper on "Community Mental Health Center Psychiatry": "All patients admitted to the mental health center should have an evaluation by a psychiatrist."[33] This issue of how directly involved the psychiatrist must be with each patient, in order to assure the delivery of quality care, is currently undergoing much debate.

Conclusion

Many have expressed concern regarding both the deterioration in the quality of patient care provided by CMHCs and the exodus of competent psychiatrists from them. Efforts by JCAH to serve as an accrediting body for CMHCs have not, thus far, proven effective. Two factors may well have contributed to this. Firstly, the JCAH community mental health "Principles" were not medically based and, therefore, may not have been sufficiently able to assure quality of care, especially for the seriously and persistently mentally ill. Secondly, the "Principles" have not enjoyed widespread use among CMHCs. Heretofore, CMHCs have not been required to meet national accrediting standards to qualify for governmental and other third-party reimbursement. Tying reimbursement to accreditation, as is done for hospitals, will solve the latter problem. Redressing the former problem might be accomplished by incorporating psychiatric standards of practice, such as those proposed in this paper, into JCAH's "Consolidated Standards Manual" and accreditation process for CMHCs. Such standards would, by linking authority to reponsibility, provide the CMHC psychiatrist with a foundation upon which he could reasonably practice and thereby assure quality patient care.

References

1. Committee on Psychiatry and Community of the Group for the Advancement of Psychiatry: Community Psychiatry: A Reappraisal. New York, Mental Health Materials Center, 1983
2. Freedman DX: Community Mental Health: Slogan and a History of the Mission, in Controversy in Psychiatry. Edited by Brady JP, Brodie HKH. Philadelphia, Pa, W.B. Saunders, 1978
3. Arce AA, Vergare MJ: Psychiatrists and Interprofessional Role Conflicts in Community Mental Health Centers, in Community Mental Health Centers and Psychiatrists. Edited by a Joint Steering Committee of the APA and the NCCMHC. Washington, DC and Rockville, Md, American Psychiatric Association and National Council of Community Mental Health Centers, 1985
4. Perr IN: New Multi-tier System in Psychiatry. The Psychiatric Times 3,#2:1,12,14,19, 1986
5. Leong GB: Psychiatrists And Community Mental Health Centers: Can Their Relationship Be Slavaged? Hospital and Community Psychiatry 33:309-310, 1982
6. Phillips P: Community Mental Health Centers — Pro and Con. Journal of the Florida Medical Association 68:103-107 1981
7. Talbott JA: Why Psychiatrists Leave the Public Sector. Hospital and Community Psychiatry 30:778-782, 1979
8. Koran LM, Chinn F, Flores S: Recruitment of Institutional Psychiatrists for the 50 States. Social Science Medicine 17:889-896, 1983
9. Berlin RM, Kales JD, Humphrey FJ II, et al: The Patient Care Crisis in Community Mental Health Centers: A Need for More Psychiatric Involvement. American Journal of Psychiatry 138:450-454, 1981
10. Langsley DG: The Community Mental Health Center: Does It Treat Patients? Hospital and Community Psychiatry 31:815-819, 1980
11. Diamond H, Cutler DL, Langsley DG, et al: Training, Recruitment, and Retention of Psychiatrists in CMHCs: Issues and Answers, in Community Mental Health Centers and Psychiatrists. Edited by a Joint Steering Committee of the APA and the NCCMHC. Washington, DC and Rockville, Md, American Psychiatric Association and National Council of Community Mental Health Centers, 1985
12. Faulkner LR, Eaton JS, Bloom JD, et al: The CMHC as a Setting for Residency Education. Community Mental Health Journal 18:3-10, 1982
13. Langsley DG, Barter, JT: In Reply. Hospital and Community Psychiatry 35:78-79, 1984
14. Fink PJ, Weinstein SP: Whatever Happened to Psychiatry? The Deprofessionalization of Community Mental Health Centers. American Journal of Psychiatry 136:406-409, 1979
15. Lehman EW, Lehman E: Psychiatrists and Community Mental Health : Normative Versus Utilitarian Incentives. Journal of Health and Social Behavior 17:364-375, 1976
16. Zusman J, Lamb HR: In Defense of Community Mental Health. American Journal of Psychiatry 134:887-890, 1977
17. Sabshin M: Community Psychiatry: Slogan or New Directions, in Controversy in Psychiatry. Edited by Brady JP, Brodie HKH. Philadelphia, Pa, W.B. Saunders, 1978
18. Cohen LH, Stricker G: Mental Health Quality Assurance — Development of the American Psychological Association/CHAMPUS Program. Evaluation & The Health Professions 6:327-338, 1983
19. Abroms EM: Beyond Eclecticism. American Journal of Psychiatry 140:740-745, 1983
20. American Psychiatric Association: Report of the Task Force on Community Mental Health Programs. American Journal of Psychiatry 139:705-708, 1982
21. Borus JF: Issues Critical to the Survival of Community Mental Health. American Journal of Psychiatry 135:1029-1035, 1978
22. Boyts H: Overview — Recruiting and Retaining Psychiatrists to Work in Community Mental Health Centers: Overcoming the Obstacles, in Community Mental Health Centers and Psychiatrists. Edited by a Joint Steering Committee of the APA and the NCCMHC. Washington, DC and Rockville, Md, American Psychiatric Association and National Council of Community Mental Health Centers, 1985
23. Tourlentes, TT: Psychiatric Administration And Medical Responsibility. Administration in Mental Health 9:154-158, 1981

24. Dewey L, Astrachan BM: Organizational Issues in Recruitment and Retention of Psychiatrists by CMHCs, in Community Mental Health Centers and Psychiatrists. Edited by a Joint Steering Committee of the APA and the NCCMHC. Washington, DC and Rockville, Md, American Psychiatric Association and National Council of Community Mental Health Centers, 1985
25. American Psychiatric Association: Position Statement On Community Mental Health Centers. American Journal of Psychiatry 130:239-240, 1973
26. Brill NQ: Delineating the Role of the Psychiatrist on the Psychiatric Team. Hospital and Community Psychiatry 28:542-544, 1977
27. Okin RL: How Community Mental Health Centers Are Coping. Hospital and Community Psychiatry 35:1118- 1125, 1984
28. Du Mas FM: Medical, Nonmedical, or Antimedical Models for Mental Health Centers? American Journal of Psychiatry 131:875-878, 1974
29. Astrachan BM: Regulation, Adaptation, and Leadership in Psychiatric Facilities. Hospital and Community Psychiatry 31:169-174,1980
30. Kubie LS: Pitfalls of Community Psychiatry. Archives of General Psychiatry 18:257-266, 1968
31. Farkas LL: Professional Standards Review Organization Implemented in a Community Mental Health Center. Journal of Mental Health Administration 5:52- 68, 1976
32. Osberg JW, Johnson FS: Improving Quality of Care and Standards Compliance in Community Mental Health Centers: A Psychiatrist & Medical Record Administrator Team Approach. Medical Record News, October:9-18, 1978
33. North Carolina Neuropsychiatric Association: Community Mental Health Center Psychiatry — Position Paper. Durham, NC, North Carolina Neuropsychiatric Association, 1983
34. Sharfstein SS: Third Party Payers: To Pay or Not to Pay. American Journal of Psychiatry 135:1185-1188, 1978
35. Beigel A, Sharfstein S, Wolfe J: Toward Increased Psychiatric Presence in Community Mental Health Centers. Hospital and Community Psychiatry 30:763- 767, 1979
36. Langsley DG, Barter JT: Psychiatric Roles in the Community Mental Health Center. Hospital and Community Psychiatry 34:729-733, 1983
37. Windle C, Ochberg FM: Enhancing Program Evaluation in the Community Mental Health Centers Program. Evaluation 2:31-36, 1975
38. Faulkner LR, Cutler DL, Middleton MH: A Participatory Planning Process for the Evaluation of Community Mental Health Centers. Community Mental Health Journal 18:169-179, 1982
39. Mcaninch M, Weedman RD, Jones RE: The JCAH Consolidated Standards: Questions and Answers. Hospital and Community Psychiatry 30:690-693, 1979
40. Langsley DG: The JCAH Accreditation Program for Community Mental Health Services: A Critical Appraisal. Hospital and Community Psychiatry 30:254- 255, 1979
41. Vuori H: Optimal and Logical Quality: Two Neglected Aspects of the Quality of Health Services. Medical Care 18:975-985, 1980
42. Maguire L: Peer Review in Community Mental Health. Community Mental Health Journal 14:190-198, 1978
43. Kopolow LE: Mental Health in the Middle: Quality Assurance and Professional Accountability. Hospital and Community Psychiatry 27:586-588, 1976
44. Mattson MR: Quality Assurance: A Literature Review of a Changing Field. Hospital and Community Psychiatry 35:605-616, 1984
45. Clark GH: President's Column. Community Psychiatrist 1:#3:1-2,10, 1986

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