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A New Beginning for the New Millenium
"*Psychiatrist Administrator*"

With this issue, the AAPA Newsletter has evolved into this news-journal. The Psychiatrist Administrator will remain dedicated to its goal of providing informative reviews of topics pertinent to psychiatrist administrators and managers in a broad scope of practice settings.

The choice of "Psychiatrist Administrator" is intended to distinguish the NewsJournal from other publications in mental and behavioral health administration in terms of its focus on the roles and perspectives of psychiatrists in leadership and management within evolving systems of care. As we change the format, content, and image of our newsletter for the new millenium, our objectives are to turn it into an appealing, exciting publication for our members and to contribute to the body of scholarly work in the area of psychiatric administration and management. This will serve AAPA mission which states:

The American Association of Psychiatric Administrators (AAPA) promotes medical leadership and excellence in behavioral healthcare systems treating persons with mental health, substance use, and/or developmental disorders. The AAPA serves as an educational, networking, and support resource for psychiatrists who are interested or engaged in administration or management. With the ultimate aim of enhancing the effectiveness, efficiency, and humanity in service delivery, the AAPA seeks to meet the needs of psychiatrists a) who have varied expertise, from novice to expert; b) who practice in sites of varying complexity, from solo private practice to large healthcare systems; and c) who represent various sectors, including public, private, and academic.

We hope that you will use this NewsJournal as one of the publications where you get your work published. We welcome your original contributions from all areas of psychiatric administration and management from all of its sectors and settings. We'd also welcome your comments on the articles and other work published in the NewsJournal.

Our editorial board, and AAPA, is very interested in your comments, suggestions, and thoughts. Please give us feedback.

Sy Saeed, M.D. Editor
The Psychiatrist Administrator

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PRESIDENT'S MESSAGE – SPRING, 2001

Gordon H. Clark, Jr., MD, MDiv, FAPA, CPE, FACPE

As this is my final "President's Message", I would like to take this opportunity to reflect on some of the significant, recent accomplishments of the AAPA and recognize those individuals and organizations largely responsible for them.

The Council as a whole has sought to revitalize the AAPA for the new millenium. Jackie Feldman spearheaded our revising of our bylaws. As a direct consequence of this revision, we have an expanded Council and now have a wealth of extraordinarily talented Councilors, broadly representing the varied field of psychiatric administration. Through a collaborative venture with the APA and BristolMeyers Squibb we have involved APA/BMS Fellows on our Council. We have revised our mission statement to encompass all areas of psychiatric administration and all levels of expertise.

As I discussed in my Summer, 2001 "President's Message", we are now engaged in an exciting consortium with the APA and a number of other psychiatric organizations. Steve Moffic's "Ethical Principles for Psychiatric Administrators", recently approved by our Council, is being forwarded on to the APA for its review and possible approval as well. We, also, have initiated ongoing liaison relationships with the American College of Physician Executives (ACPE) and the American Association of Community Psychiatrists (AACP). I want to thank Mary Ellen Foti, John Ludden, and Charley Huffine for serving as Liaisons to the APA, ACPE, and AACP respectively. I hope these liaison relationships will become even more meaningful over time.

I want to thank all our Committee Chairs, listed elsewhere in this "NewsJournal", for developing charters for their committees, for engaging our Members in these committees, and for accomplishing what they have to this point. I want to thank those who have chaired and participated in the important AAPA programs that have been offered at the APA Annual Meeting and Institute on Psychiatric Services. Paula Panzer, as President of our New York Chapter, has also done an extraordinary job of enabling that Chapter to put on some very significant programs.

As you know, a newsletter is, typically, an organization's life blood. Gloria Faretra, a former President of the AAPA, most ably wore the mantle of Editor for many years until her recent retirement. Sy Saeed succeeded Gloria and, as of this issue, has transformed the newsletter into a "NewsJournal", incorporating peer reviewed articles for the first time. Tom Simpatico is "Webmaster" of our new website and manager of our soon to be listserves for both our Membership and our Council. These internet technologies will adjunctively serve our organization in a life blood capacity. I want to thank Wyeth-Ayerst and Pfizer for their generous funding of the newsletter/"NewsJournal" and website/listserves respectively.

While I'm on this anatomical metaphor, clearly the backbone of the skeletal structure of our organization is our Executive Director, Frances Roton. Frances is a jewel of a person and a talented administrator. She is organized, caring, committed, and a lot of fun. She has made my job both manageable and enjoyable. Without her abiding shepherding, I'm afraid we'd be a bunch of lost balls in the weeds!

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THE PSYCHIATRIST-EXECUTIVE IN THE PUBLIC SECTOR: CLINICIAN, ADMINISTRATOR, LEADER, FOLLOWER

A. Anthony Arce, M.D.

Doctor Arce receives the 2000 APA/AAPA Administrative Psychiatry Award at the IPS Meeting in Philadelphia.

In retrospect, many of us think of the decades of the 60's and 70's as the Golden Age of psychiatric administration. Psychiatrists were executives of state mental health departments, state hospitals and community psychiatric facilities. I began my career as a clinician administrator then and in the ensuing decades, I have held administrative posts in a County Hospital, a State Department of Mental Hygiene, a state hospital, a variety of public sector service providers and in academia. During that same span of time, I have also witnessed how we, as psychiatrists, grew dissatisfied with the diminishing role of psychiatry in the mental health field and abdicated our leadership in the public sector. As managed care transformed healthcare delivery from a "service industry" into a "product industry" we were replaced by other professionals with degrees in hospital, public or business administration. When I was a fledgling administrator, we used to be concerned with developing programs to fit patient needs. Today, we speak of "product lines" and "profit margins".

In 1983, Walter Barton, former Medical Director of the American Psychiatric Association during whose tenure the Committee on Administrative Psychiatry was established, contemplating the future of medicine, described a medical system dominated by dialogues between patient and computer. Algorithms would direct the inquiry and the computer would spew out diagnosis, suggest therapies, dispense drugs, and generate bills for all expenses and reports to the many regulatory agencies. Because of the nature of our specialty, he also predicted that psychiatrists might become the last bastion of human contact in a machine dominated medical system. But, decrying "the passivity [that] characterizes psychiatric organizational behavior", he wondered whether we would become "victims of change or planners of the future", and whether we would be "responsible for improving the quality of care or just content to deplore it?"

In the mid 1990's many psychiatrists believed that things would only get worse but, in fact, have gotten better. Ironically, an unanticipated side effect of the managed care era has been the remedicalization of mental health services. Psychiatric expertise has come to be regarded as encompassing indispensable skills that are required to maintain the quality of mental health care, although some cynics may believe that it is just a ploy by managed care organizations to shield them from liability. Nevertheless, the need for such expertise has led to an increase in the number of opportunities for future psychiatrists to once more assume administrative leadership.

The field of public psychiatry encompasses, besides the state hospitals, a broad array of mental health care providers that render a variety of services to the psychiatrically disabled and derive their revenue primarily from combinations of federal, state, county and city funding streams. The system in its various configurations serves primarily the uninsured indigent as well as the majority of recipients of

medical assistance. Public sector providers far outnumber those in the private sector and their need for psychiatrists is often greater than the number of available candidates. Approximately 80% of new psychiatric residency graduates start their careers as either full time or part time employees in the public sector as staff psychiatrists or "medical directors".

A recent survey by Columbia University's Public Psychiatry Fellowship of the membership of the American Association of Psychiatric Administrators and the American Association of Community Psychiatrists revealed that the familiar term medical director is used to designate a variety of about six generic positions that denote "psychiatrists who function in ill defined relationships with non physician executives". These positions often encompass a mixture of clinical and administrative responsibilities that are fluid and can change basically at the whim of the non physician executive. The survey also revealed what the authors refer to as a disconnect between the tasks that psychiatrists indicated contributed to job satisfaction and those that analyses of the survey showed actually do contribute to job satisfaction. Most psychiatrists responded that the clinical aspects is what makes them happy in their jobs but the survey showed that administrative tasks correlate more highly with job satisfaction. The authors conclude that the "ability to influence the quality of care through administrative, rather than clinical avenues" is the significant factor in job satisfaction.

Administration is an integral part of all professional functioning regardless of the title or status in the organization. The way we handle those responsibilities influences all of our work. The demand for mental health services has increased and the delivery of care has grown complex as a result of scientific and technological advances, the proliferation of providers, the intrusive oversight by governmental and judicial bodies, and the financial constraints of reduced allocations and managed care. The provision of services depends on the confluence of many constituencies, both internal and external to the organization. Quality patient care hinges on the effective collaboration of various professional disciplines and nonprofessional staff within the organization as well as among disparate providers in the broader community.

A point can be made that the role of the psychiatrist executive subsumes four functions or sub-roles: clinician, administrator, leader and team player. They are not mutually exclusive but rather constitute an integrated whole with one or another being emphasized depending on the issues being addressed or the personality and style of the individual. However, the order in which I have listed them reflects my biased priority.

A physician psychiatrist is first and foremost a healer and his primary allegiance is to the patient. Our training provides us with a unique knowledge base and set of skills that integrate, as Sabshin put it, "the inseparability of mind and body, the social nature of man, and the many problems that must be confronted in life". We are the clinical conscience of our respective organizations. It is this unique perspective that must inform all other aspects of our activities on behalf of patients, whether it is program development, forging alliances with other providers, formulating policies and practices to satisfy licensing and accreditation standards, or advising CEO's on the potential impact of proposed contracts on clinical care. This clinical activity also includes guiding and supervising staff at case conferences, providing consultations in a difficult case at the request of a colleague, or engaging in actual patient care. Maintaining a clinical presence not only provides a role model for staff but also makes it imperative that one keep up with advances in nosology, pharmacology and therapy.

The second and third functions on my list - administrator and leader - are closely linked. Talbott has discussed the differences in meaning between management, administration and leadership. The word management implies a hands-on role involving oversight of a discreet

program unit such as an outpatient clinic or inpatient ward and encompasses such functions as "planning, organizing, staffing, directing, coordinating, reporting and budgeting". The functions of an administrator are broader. They involve such elements as organizational structure, systems and procedures, shared values, corporate strengths and skills, and public relations. Leadership is more difficult to define. Talbott devised the acronym VIBRANT IDEAS "to "conceptualize what leadership in and of itself involves". The acronym stands for vision, inspiring others, bringing others along, risk taking, aggression, nurturance, task orientation, insight, doing, example, ambition and setting priorities. "Managers can act and administrators can oversee but only leaders can move us ahead".

The administrator, as leader, must understand the relationship between the individual and the organization. Shore has remarked that people work not because of rewards and punishments but because of the symmetry and connections between their own values and the transcendent purposes of the organization. This is often expressed in our pride in the place where we work and our role in it. By keeping in focus the organization's mission and values and an awareness of his or her relationship to them, the leader can more effectively guide others and offer a significant identification figure.

The fourth role - "follower" or team-player - reflects my perception that I have both led and served the organizations for which I have worked in the same sense that I have led and served the staffs that have comprised them. I have already alluded to fostering the organization's values and fulfilling its mission, internally and externally. Equally as important is the maintenance of the organization's identity and viability in the face of competing bureaucratic, financial and political pressures. Often the balancing of patient needs and organizational demands is a daunting task. Organizational priorities have to be considered in any decision making, with negotiation and compromise being the chief tools in arriving at working solutions that blend quality patient care and organizational viability.

Greenblatt referred to the administrator as a boundary manager. Referring to hospitals, he wrote that they are "loosely integrated institutions, with many semi-autonomous units [staffed] by individuals with divided loyalties [institutional vs. professional].... This requires a delicate blending of subtle and diverse elements into a totality in which the end product is largely intangible". The same can be said of the diversity and complexity of our current mental health system. Our effectiveness as psychiatrist executives depends heavily on how well we function as boundary managers both internally and externally.

Peele has reviewed the external sources whose differing values affect the care of the psychiatrically ill and raise ethical issues for the psychiatrist administrator. Keill has explored the psychiatrist-executive as a political being at the interface between the political system and the mental health system. He emphasized that as psychiatrist executives we constantly need to improve our diagnostic and treatment skills, to be efficient fiscal managers and to acquire skills in the political arena.

But besides all the turbulent forces than can knock us around when we work with other systems, much of our work involves handling the stresses inherent to organizational dynamics. We attempt to minimize these tensions by constructing organizational charts, generating volumes of policies and practices, designing job and program descriptions, and above all, having meetings. Although we may delegate responsibility to managers for the daily administration of these affairs, not infrequently we find ourselves to be a court of last resort. The training and skills we have acquired in understanding how people work and the nature of relationships are of assistance in these situations.

The administrator as an internal boundary manager must assume that, unless proven otherwise, everyone who is committed to an organization works towards maximizing

outcomes. The work is carried out via complex relationships among individuals within the organization as well as their respective relationships with the organization. These relationships may be defined in formal or informal terms and are affected by lateral and vertical accountabilities as well as by narcissistic needs and personality patterns. They are also subject to shifts depending on the issues being addressed but, in order to withstand the fluidity, must be built on mutual respect and an appreciation of the importance of each individual's contribution to the whole. We must respect our subordinates as much as we expect our superiors to respect us.

Shore has pointed out that some of the metaphorical formulations we use to organize observations of behavior are quite useful in administration and their usefulness depends on how they are blended with the administrator's character and values. Although we may have an understanding of the psychodynamic forces in situations involving internecine stress and conflict, in dealing with them anything smacking of therapy is to be avoided. Reality issues must be addressed and dealt with openly. On the other hand, some of the most useful administrative ideas and techniques are at odds with what we are trained to do. Many problems that are often misdiagnosed as acting out on the part of staff turn out to be rooted in vague job descriptions, inadequate performance evaluations or insufficient feedback and reflect the failure to apply basic management skills to clinical operations. It is not surprising that psychiatrists assuming administrative positions have difficulties in this area. These are skills that are not taught either in medical school or psychiatric training. In medical school, the teaching of administrative skills are thought to be unworthy of consideration as if there were something ignoble about learning administrative skills so essential to medical practice these days.

We must be on guard for the passivity that our training inculcates; that is, substituting process for action. Some issues benefit from elapsed time and evaporate when they are given reasonable inattention. Interminable processing in pursuit of consensus can be destructive. The administrator's job is to take action, to make decisions and to exert authority. Keill in exploring the use of power, states that a boss who exerts his or her coercive, reward and legitimate powers is also one that can affirm, validate and approve. We cannot take care of patients in organized settings without a structure of relationships that insures accountability and authority.

The importance of working in partnership with others, whether it is a consumer, an administrator, a colleague or a system cannot be emphasized enough. As psychiatrists we are trained to appropriately distance ourselves in the therapeutic interaction so we don't take things personally. In the work situation, although everything feels personal and frequently is, we should be able to step back and examine the interaction objectively so we can figure out how we should approach the relationship whether it is with a non-productive staff member, an adversarial colleague in a HMO, or a recalcitrant CEO. The more in control you feel, the less likely you are to act out inappropriately. The most crucial relationship of all is the one forged with whomever is the "boss" whom I shall designate collectively as the CEO. The organizational power that the psychiatrist administrator can achieve is dependent on the relationship with the CEO and this, in turn, can critically affect organizational decision making.

It is society's task to decide who is going to be served. It is the CEO's task to decide how it is going to be done. But, it is our profession's task to insure that patient care is of the highest quality attainable. Psychiatry has a collective ethical duty to maintain the quality of care in all mental health services, public or private. But in the end, it is the psychiatrist executive who best speaks for the patient and whose responsibility it is to lead the way.

Dr. Arce is with the Girard Medical Center of Philadelphia, PA.

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President's Message continued

In conclusion, I want to thank you, the Members of the AAPA, for your abiding interest in and support of the work of the AAPA. I encourage you to let Chris Fichtner, our incoming President, know if you wish to become more actively involved in the AAPA. There's certainly plenty to do for as many as want to do it. Also, I encourage you to join us for the 40th Anniversary Gala Celebration of the AAPA in New Orleans. Forest Pharmaceuticals is providing us with a generous grant to have what should prove to be a lovely reception at Arnaud's, complete with a jazz band. If you can come the evening of Tuesday, May 8th, please RSVP to Frances.

Thank you, Members of the AAPA and Members of its Council, for allowing me the privileged opportunity of serving as your President. I am proud of what we have accomplished together thus far and eagerly look forward to that which is yet to come.

Commentary on Dr. A. Anthony Arce's Paper, *"The Psychiatrist-Executive in the Public Sector: Clinician, Administrator, Leader, Follower"*

Christopher G. Fichtner, M.D.

With the wisdom of a seasoned psychiatrist executive, Dr. A. Anthony Arce offers us a richly textured appraisal of administrative psychiatry. Blending the tutelage of some of the field's most prominent mentors with reflections from his own extensive experience as "clinician, administrator, leader, and follower," he sets the development of administrative psychiatry within the context of the struggle to assure that mentally ill patients receive care–especially in the public sector. Humbly, he acknowledges his debts to many, while with astute commentary he enriches our appreciation of the distinctive tasks and methods of our practice as psychiatrist administrators. In developing his theme of the multiple roles of the psychiatrist executive–the modes within which the psychiatrist administrator carries out his or her work–Dr. Arce raises numerous important issues. Space here affords the opportunity to address but a few.

Dr. Arce's reference to the 1960s and 70s as the "Golden Age" of psychiatric administration made me wonder about the "ages" in the evolution of the field. Surely, in some sense there was a great dawning of administrative psychiatry–to which organized psychiatry itself owes its very origins to a significant extent–in the Association of Medical Superintendents of American Institutions for the Insane. This is not to romanticize a time when possibly the only physician caring for hundreds of inpatients happened also to be in charge of the institution. Then again, I wonder whether we are now coming "full circle" or returning to our origins–and if so, whether this is a good or bad thing. Dr. Arce identifies both the serious problems with, and the opportunities that may be afforded by, contemporary managed care with respect to psychiatry. Have we a utopian age yet to come? While visionary prognostications regarding our field typically emphasize research advances with direct diagnostic and treatment implications (genetics, molecular biology, neuroimaging, biomedical engineering) (1), we are challenged as administrative psychiatrists to envision and create the mental health delivery systems of the future with socio-cultural strides that keep apace of the leaps and bounds of their biotechnological counterparts (2).

Dr. Arce mentions his work within academia as well as public psychiatry, but does not elaborate on how academia interfaces with the public sector, or on the psychiatrist administrator's role in linking the two. As administrator, leader and follower, the psychiatrist administrator exists not only within a hierarchical context, but also within any number of networks which afford some measure of opportunity to facilitate system and subsystem links. That is, existing at the interface of systems and subsystems the psychiatrist administrator is poised to act as facilitator of linkages–exporting and importing resources, expertise and culture across the boundaries. When academic medicine is viewed as an accessible system or subsystem, the public psychiatrist administrator has the opportunity to import a culture of critical inquiry into the service system. For example, Dr. Sy Saeed, Department Chair at the University of Illinois College of Medicine in Peoria and Clinical Systems Administrator for the state's *Northcentral netWork*, re-crafted the state hospital's mission statement to define its enterprise as providing "evidence-based treatment within a setting of education and inquiry." His view–one which I share–is that a context of education and inquiry (both in the broadest sense) is an essential component of state-of-the art practice. And all this is highly relevant to politicized public sector contexts: these days, legislators want to know if there are compelling reasons–in terms of the results to be expected, i.e., the data–for funding new initiatives and for not withdrawing funding from existing ones.

Recently, at a program on physician leadership and management, I fell into a discussion with another physician–a quadruply-boarded, critical care internist-pediatrician–on the structure and function of multidisciplinary teams in various

branches of medicine, which led to our considering the possibility of collaborating on a project in the area. Several things were apparent to both of us: functional multidisciplinary teams are essential in the work we do; the same is true in other areas of medicine; teams function differently in different specialty areas of clinical activity; the team concept appears to be more important in some areas of medicine than in others; and in at least some settings, it would appear that the team concept is underdeveloped and the practice field has not taken advantage of as many potential bridges to non-physician professionals as other areas of medicine and/or as is possible for the future, stretching beyond current modal configurations and standards. I cite this conversation not so much to get into a discussion of teams—although that is certainly a theme in Dr. Arce's paper—but to offer it as an illustration of some related issues, noted by Dr. Arce, on which psychiatry has had to weigh in over the years, and especially in the years since that "Golden Age." These include: psychiatry's relationship to medicine, psychiatry's relationship to non-medical mental health disciplines, and how to use the special expertise that psychiatrists bring to their practice to inform their understanding of human behavior in the context of groups and organizations.

Whether psychiatrists are at this point in history any better than other physicians at thinking about such matters is a question for which the answer is unclear; however, I would argue that at best our training equips us with skills that create an advantage, inasmuch as our psychodynamic tradition constitutes a technology geared toward the expansion of awareness. The methods of investigation implied by this tradition lead to a rich data-gathering strategy not unlike what anthropologist Clifford Geertz, borrowing from philosopher Gilbert Ryle, called "thick description" (3). Creative application of such methods, in my view, blends imperceptibly with development of the imagination, and with cultivation of the capacity for creative "visioning." Such skills are core competencies in organizational and systems leadership, with mental health systems being no exception. Problem is, even as the current increase noted by Arce in opportunities for administration and leadership unfolds, psychiatric education may be paring back training in the tools that confer advantage upon the field in unlocking the human creativity essential to the crafting of our future health systems. While many will no doubt disagree with this formulation, I would suggest that the affinities between applied psychoanalysis and what Canadian organizational consultant and professor Gareth Morgan calls "imaginization" are more compelling than the distinctions (4).

I can now imagine Dr. Arce responding that I am perilously close to advocating what he cautioned against: making any organizational intervention that "smacks of therapy." But I would suggest that if it "smacks" at all it is probably bad therapy, and undoubtedly a bad organizational intervention. If in earlier iterations administrative psychiatry committed the error of overutilizing a psychoanalytic framework, it may be wise to attempt to distill the essence of that error before throwing out the baby with the bath water. This really raises two distinct issues: first, whether there is a retrieval of that framework that is useful for the purposes of organizational management and leadership; and second, whether our training programs will produce many psychiatrists with skills to recognize and apply it. I have greater confidence in the former, but certainly some hope for the latter. In question is whether psychiatry as a field will continue to represent any concern with the multiple levels of meaning associated with individual and collective experience, and whether that concern will be reflected in any special interpretive skills. I have little doubt about the value of such skills in organizational leadership.

Finally, Dr. Arce touches on the rapidly evolving role of information technology in psychiatric administration, and provides some truly visionary quotations from Dr. Walter Barton. These perspectives–both from Barton and from Arce–prime us for the further discussion we would like to have: How can we use both our clinical and administrative expertise to facilitate patients' evaluation of vastly greater amounts of information than have yet been available? And as we enter into this discussion it becomes clear that addressing information technology must also bring up the reality of the consumer movement. Because, to be sure, consumers of our

services will have electronic access to ever greater amounts of information, and will seek in their therapeutic professionals collaborators who will work *with* them, and empower them to make decisions for themselves. To the extent we are able to rise to the occasion on this issue, the computer will become our ally, and our alliance with our patients will become even stronger. To the extent that we are unable to do so, we will meet the same fate seen in other sectors of the economy: the ineffective practitioner will be replaced by the user-friendly machine.

Dr. Arce has constructed an account of our work that serves as a powerful stimulus for reflection on the practice of administrative psychiatry. Above all, it is with great respect, admiration and a deep sense of gratitude that I offer the above thoughts in response.

Dr. Fichtner is with the Illinois Department of Human Services, Office of Mental Health, Chicago, IL.

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Tuesday, May 8, 2001

Annual Membership Meeting

12:00 noon

Hampton Inn - Convention Center

Riverside Room I - Lobby Level

New Orleans, LA

Joseph A. Flaherty, M.D.

" Public - Academic Partnerships: From Rhetoric to Realism"

Implementing Medication Algorithms: The Texas Experience

Karla K. Starkweather

and

Steven P. Shon, M.D.

Mental health professionals in the public sector struggle to provide quality care with limited resources while payors increasingly scrutinize the budgets for these services. The influx of patients entering the public mental health system places an additional burden on an already strained system.

In collaboration with Texas medical and pharmacy schools and consumer advocacy groups, the Texas Department of Mental Health and Mental Retardation created the Texas Medication Algorithm Project (TMAP) to address some of the problems in the Texas public mental health system. TMAP developed and tested medication algorithms or treatment guidelines in the three major mental illnesses – major depressive disorder, schizophrenia and bipolar disorder[1,2,3]. The project included four phases: algorithm development, a feasibility test, a comparative study of the algorithm package versus treatment as usual, and implementation in the Texas system.

TMAP is a disease management model and encompasses these components:[4]

- Evidence-based, consensually-derived clinical guidelines that include strategies and tactics for medication treatment
- Clinical and technical assistance, education and supports necessary to ensure proper implementation
- A patient and family education program specific to each disease and with multiple levels
- A uniform documentation system

In the initial stages of conceptualizing TMAP, the project management team invited advocacy groups, professional organizations, and provider representatives to join in discussions of the project[5,6]. The opportunity for stakeholders to become part of the planning process helped to secure acceptance and support. Stakeholders also served in important roles during the development of the algorithms and the patient/family education program and continue to be involved as the algorithm packages are revised.

Guiding principles for developing the algorithms were established[7]. The safest and most efficacious medications should be used first and more complex interventions should be used only after a patient fails on simpler strategies. When appropriate, multiple options should be included in each algorithm to give both the physician and the patient a choice for which treatment best suits the situation. Brief rating scales should be used to determine response and provide decision support for medication continuation or change. An education program should be developed to teach patients and families about the disorder and treatment. The algorithm packages developed included all these principles.

During Phase 1 of TMAP, algorithm development took place using consensus conferences for each of the three disorders[5]. National experts in the mental health field, consumers and advocates, psychiatrists practicing in the MHMR system, and administrators participated in the conferences. The conferences resulted in evidence-based algorithms using expert consensus when the evidence ran out, with the idea that they would be updated as new science appeared. The algorithms are intended to be a basic framework from which a clinician works to determine the best treatment approach. This approach should decrease variability in clinician prescribing habits and provide ample choices in tailoring the treatment to the patient's needs. Physician manuals for each disorder include strategies and tactics for using the algorithms. When a new medication comes on the market, the documentation will be reviewed and recommendations made as to where the medication should be added in the algorithm, and when it is most appropriately used. For example, in August 2000, another consensus conference was held to revise the bipolar disorder algorithms to reflect the latest

scientific evidence and the advent of new medication. The results from this conference should be available in the summer of 2001.

Psychopharmacology was chosen as an initial focus because, in spite of significant evidence for rational pharmacotherapy, considerable variance exists in actual prescribing practices[7]. Appropriate medication treatment significantly increases the effectiveness of other treatments and consumers' abilities to participate in psychosocial rehabilitation programs. As new medications become available, the algorithms provide a framework in which to integrate this new information into logical, sequenced treatment plans.

Another component of TMAP is the clinical and technical assistance, education, and supports attached to the algorithms[6]. During phases 2 and 3 of TMAP, physicians and their clinical coordinators received initial training in the use of the algorithms, the symptom measures and other assessment instruments used in conjunction with implementation. The educational sessions provided current research and medication information related to the project.

Weekly or bimonthly conference calls provided ongoing technical assistance to the clinicians during phases 2 and 3. The conferences gave physicians the opportunity to ask questions about treatment strategies for individual patients and allowed experts to disseminate up-to-date information on new medications and treatment approaches. These sessions also allowed the opportunity to discuss challenges with implementation and to perform problem solving. Additionally, physicians were encouraged to call the experts for consultations or advice. Continuing Medical Education credits were offered for the educational sessions and the conference calls to encourage clinicians to participate.

A comprehensive patient and family psychoeducation program is a third component of TMAP[4]. The phased education package provides information about symptoms of the particular disorder, benefits and side effects of prescribed medications, coping techniques, self-monitoring aids and patient/family education and support groups. Initially, patients receive simple information about the symptoms of the disorder and the medication prescribed. As they become more stable, more in-depth material is introduced. The materials are available in both English and Spanish, and consist of written, visual, and verbal interventions.

Consumers and advocates, as well as mental health professionals, served on the team to develop the psychoeducation program. Because consumers know best which types of education makes sense to them, many of the materials were created by consumers. While the program emphasizes an understanding of the disease, self-monitoring techniques, and medication benefits and side effects, it also encourages consumers to become active participants in the treatment process. In doing so, patients should become more adherent to their medication regimen.

Another component of the TMAP philosophy is a uniform documentation system. During the study, several forms were created to help capture data needed for research. In using this new system, physicians document the rationale for changing or continuing patients' treatment approaches. Symptom measures are recorded as well as consumer self-report notes. The records allow the clinician to evaluate the response to treatment over time and provide a uniform documentation system that can be reviewed when a different provider is used. These forms have since been revised for use in implementation to provide consistent documentation throughout the Texas mental health system. The forms can be viewed at our web site: www.mhmr.state.tx.us/CentralOffice/MedicalDirector/TIMA.html

TMAP Phase 2 studied the feasibility of using the algorithms in the clinical setting[8]. The trial took place at 16 sites in the Texas mental health system and involved both inpatients and outpatients. Clinical outcomes in treated patients were overall positive, and satisfaction surveys showed that both clinicians and consumers were satisfied with the medication algorithm package.

The third phase of TMAP, which ended on March 31, 2000, was conducted to provide a comparative evaluation of the clinical and economic aspects of treatment with algorithms versus treatment as usual[9]. The study included more than 1,400 consumers in 19 outpatient clinics across the state of Texas.

Researchers are analyzing the data and results will be reported in professional publications.

TDMHMR has begun implementing the algorithm packages in the public mental health system. This initiative is known as the Texas Implementation of Medication Algorithms (TIMA) or TMAP Phase 4. During the research phase of TMAP, many resources were available that are not normally available in a public clinic[7]. Therefore, restructuring clinics and reallocating funds to incorporate the strategies and tactics employed in TMAP continue to present challenges.

An important aspect in the study included the use of clinical coordinators to assist the physicians in implementing the algorithm packages[7,8]. Besides collecting data for the study, the coordinators administered disorder-specific clinical assessments before physician visits, prompted physicians regarding steps in the algorithm, and conducted the family and patient education program. The coordinators also implemented procedures to increase the likelihood that patients kept their scheduled appointments and followed up with patients who missed appointments. TMAP physicians reported that they liked having the partnership of the clinical coordinator because these individuals provided additional support and information to help the physicians make informed decisions about patients' treatment plans. In TIMA, the resources necessary to support this position often cannot be found so the functions of the coordinator need to be performed among several staff members in multiple disciplines. This is a major challenge to implementation, as the clinical or algorithm coordinator is crucial to the TMAP disease management philosophy.

Psychiatric appointments are often scheduled every fifteen minutes. This amount of time may be sufficient for some stable patients, but is unrealistic to address multiple issues of more symptomatic patients. To properly implement the algorithms, it is suggested that the time allotted for appointments and the frequency of visits be increased until the patient becomes stable. This gives the physician more time to perform assessments, evaluate response, and tailor the algorithm recommendations to the individual. Nurses or other appropriate clinical staff may perform assessments and symptom measures before the physician visit and see patients between physician visits to check progress and evaluate medication response. Clinical staff also initiate interim telephone contact to follow up patients. This additional contact with patients provides physicians with valuable information, allows them to use their time more efficiently, and increases patient adherence with treatment.

The patient/family psychoeducation program was reported to be successful in helping to build better relationships between physicians and patients. The educational program in the algorithm package goes beyond what is usually offered in most mental health systems. Patients that are educated become more actively engaged in the management of their disorder and more aware of improvement and/or recurrences. The clinical coordinator assumed this duty in TMAP, but in TIMA a multi-discipline approach must be taken because of the lack of a designated patient educator. Although nurses, social workers, case managers, and rehabilitation services personnel administer the education program, the TMAP philosophy maintains that having one person responsible for implementation enhances the process. Center staff report an increase in family participation in the treatment process that can be attributed to the education program. Some clinics use the education program in skills-based training classes. Mental health centers, with the help of TIMA trainers, are identifying, recruiting, and training consumers and family members to become actively involved in the program as education group facilitators.

Communication and education of staff responsible for implementing the algorithm packages poses another challenge in TIMA. Clinicians receive training in the algorithms and are encouraged to call in for individual consultation. Conference calls have been set up bimonthly to provide a forum for clinical and academic experts, physicians and other staff to discuss TIMA implementation. Initially, these conferences focused on staging, how to use the algorithms and therapeutic consultations, as well as new medications and treatment approaches. The calls have since been divided into clinical issues and administrative issues. While one conference call a month continues to be devoted to medication and

clinical issues, the second call centers around the patient/family education program, quality improvement and other implementation issues. This gives participants the opportunity to network and share ideas with staff at other mental health centers.

Other methods to disseminate information and expert clinical support continue to be explored. Although conference calls have many benefits, some people are reluctant to interact in this manner and the calls take time away from patient care. As computers become more readily available in clinics, list servers and e-mail may provide another acceptable method to communicate with clinicians.

Using a uniform documentation system is intended to provide essential information about the patient's history and current course of treatment, which will increase continuity of care and improve patient outcomes. Rating scale results, symptom measures, and rationale for decision making are also included in the record. This information is important since many patients in the public sector will have multiple treating physicians throughout their lifetime.

Although the TIMA documentation forms have been approved by TDMHMR's Medical Records Committee, some centers require physicians to continue to use existing procedures while adding the new forms. The duplication of effort has caused some resistance to the use of the TIMA format. The forms were designed with the idea of streamlining the patient record and eliminating unnecessary information. System changes are encouraged to transition to the uniform documentation. These forms also allow for the uniform collection and analysis of data which provide information on patient outcomes, feedback to the provider, and quality improvement efforts.

Transitioning to the new documentation system takes time. Physicians may replace existing clinical notes with the TIMA clinical record form immediately. Some centers report that they are beginning to adopt the new documentation system as new patients enter treatment. When a patient requires a medication change, it is suggested that nonphysician staff complete the history (intake) form under the physician's direction.

TDMHMR, in collaboration with The University of Texas College of Pharmacy, is in the process of developing a quality improvement toolkit to monitor use of the algorithms. The toolkit will include checklists to aid QI staff in determining if the algorithm used is consistent with the patient's diagnosis, if the medication regimen is consistent with the stage, if therapeutic doses of the medications are prescribed and if adequate trials on medications are being used. Other items will be added to the checklists over time. These quality improvement activities could possibly influence physician adherence to the algorithms.

Other algorithm projects have grown out of TMAP. Among these are a children's medication algorithm (CMAP) project, computerization of TMAP (CompTMAP), and a multistate algorithm project.

The Children's Medication Algorithm Project (CMAP) is designed similarly to TMAP, focusing on optimal outcomes. The development of algorithms (Phase I) took place during the summer of 1998. Experts and stakeholders gathered at consensus conferences to develop guidelines for attention deficit/hyperactivity disorder (ADHD) and major depressive disorder (MDD) in children. Phase II, now in progress, is a feasibility study of the consensually-derived treatment algorithms in the Texas public mental health system.

CompTMAP will provide an interactive, computerized version of the algorithms. The physician manuals that accompany the algorithm diagrams require frequent reference to ensure proper implementation. The software contains all the information included in the manuals, provides a computerized medical record, and provides instant feedback to the physician regarding algorithm adherence. CompTMAP will serve as a database from which data can be extracted regarding patient outcomes with different medication regimens, cost of treatment, and other vital decision-making information.

Because of widespread interest in TMAP, the TMAP/TIMA technical assistance team is now working with other states in the Multistate Algorithm Project. Funding has been secured for the team to assist six states to tailor the medication algorithm packages for use in their public mental health systems over a 12-month period. The plan begins with gaining

commitment to successful implementation. This involves inviting stakeholders (providers, administrators, consumers, advocates and payers) to a briefing about the rationale and goals of the algorithm packages. The team also provides training and technical assistance to physicians and other staff in using the algorithms. A quality improvement component, as well as training in developing a patient/family education program, is also included in this project.

TDMHMR is planning future algorithm projects as well. A consensus conference to add psychotherapy to the major depression algorithms will be held late in 2001. The TMAP/TIMA team recognizes that medication does not cover the extent of treatment required by patients with severe and persistent mental illness. The lack of psychotherapy and other psychosocial interventions has been a common criticism of TMAP although, as previously stated, medication is a beginning in improving patient functioning, thereby increasing the effectiveness of other treatment strategies. This consensus conference and others being planned for the future will move the medication algorithm initiative closer to a comprehensive disease management approach.

The development of algorithms for co-occurring substance abuse and mental illness (COMAP) are also planned by TDMHMR in collaboration with medical and pharmacy schools. The department has applied for grants to support this project. Phase I will be a consensus conference to integrate best practice guidelines for patients with Axis I mental disorders and co-occurring substance abuse.

Conclusion

It is becoming increasingly clear that healthcare organizations must demonstrate to payors and consumers that they are delivering quality care. Clinical guidelines and algorithms that are based upon scientific evidence and expert clinical consensus offer powerful tools to fulfill this demand. In Texas, TMAP used this approach to develop medication algorithms for three major mental disorders – major depressive disorder, schizophrenia, and bipolar disorder. Using a collaborative and inclusive process, TMAP had broad acceptance and support from professionals, researchers, family members, consumers, and other advocates. An important feature of the project was the use of a uniform medication documentation format that promotes outcome based clinical decisions. Aggregated data derived from this documentation format in the TMAP Phase 2 study was used to demonstrate to the Texas legislature that measurable positive outcomes could be achieved using the algorithm methodology. This data along with strong advocate support, helped convince the legislature to increase public mental health funding by an additional $35 million per year. Finally, a comprehensive patient and family education program was developed as part of the TMAP intervention. Essentially consumers, family members, and advocates developed the program. It contains multiple and different educational approaches, e.g., written, verbal, visual, etc. It also contains a consumer to consumer education component and all materials are available in English and Spanish. This part of TMAP has helped promote better consumer understanding of mental illness, medication treatment, responsibilities, and adherence to medication treatment regimens.

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Welcome! New Members

December 2000

Kenneth H. Cotton, M.D.
Laurence H. Miller, M.D.
Thomas Newmark, M.D.
J. Mark Rowles, M.D.
Sudarshan K. Suneja, M.D., Ph.D.
Pedro Ruiz, M.D.

February 2001

Jeffrey M. Levine, M.D.

The Role of the Psychiatrist in Community Mental Health Centers: What Should They Do? How Many Do You Need?

—Developing measurable guidelines and standards for clinical practice
—Deriving a formula to estimate an appropriate psychiatrist staffing level

Louis J. Mini, M.D., Mark Hantoot, M.D., Malini Patel, M.D.,
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Section I:

Over recent decades, there has been a large migration of patients from the state psychiatric hospitals to the community mental health centers (CMHCs). As a result of this movement, an increasing burden has now been placed on CMHCs to meet the comprehensive needs of this rapidly increasing patient load. These treatment and rehabilitation needs, especially in regard to the seriously and persistently mentally ill, have tremendously taxed available human resources at most community mental health agencies. In many states, there are numerous CMHCs that sorely lack adequate psychiatrist staffing to meet the needs of their patients. In addition, a glaring deficiency in medical psychiatric leadership is evident in many public sector outpatient psychiatric clinics throughout the US. These factors carry with them a multitude of complex problems which greatly impact the availability of quality psychiatric care in the community mental health center setting.

In most community mental health centers, the role of the psychiatrist has traditionally focused almost exclusively on diagnostic assessment and the prescribing of medication. Many CMHCs do not have identified Medical Directors nor any psychiatrist in a position of leadership to help drive clinical programs. It is clear that proper allocation of psychiatrist time in the community mental health centers is a factor which requires greater investigation. The amount of time a psychiatrist should spend doing direct patient care versus providing indirect services is an issue often not well negotiated between the administration of CMHCs and the psychiatrists in their system. Also, the use of psychiatrists in clinical administrative roles is not always highly valued in some organizations. Unfortunately this can lead to incomplete clinical understanding of patients needs, inadequately developed programs, and psychiatrist burnout when their role is limited to seeing large numbers of patients in a short time. Strong psychiatric leadership in the community mental health center is greatly needed, not only from a direct clinical standpoint—but also in regards to fiscal decision making, supervision, and overall quality management. However, obstacles to these initiatives are often due to financial constraints, or an inability to recruit highly qualified psychiatrists into such systems. In many states, there is great variety in their respective community mental health centers. This type of diversity is especially common in states where there are distinct metropolitan, suburban and rural areas. Throughout the state of Illinois for example, there are nine geographic networks providing adult outpatient psychiatricservices, each consisting of various numbersof CMHCs. The comparative psychiatrist to patient ratios in these various CMHCs are greatly disparate. In a 1999 survey, it was found that the total number of patients per full time physician in the Illinois public sector outpatient networks for adult mental health services ranged anywhere from 854 patients per physician to 2,883 per physician. In addition, CMHC's in these networks tend to be heterogeneous in nature and their patient populations can vary considerably. For

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example, an inner city CMHC may have a highincidence of acute patients, those with substance abuse disorders, greater psychosocial dysfunction, or that may require a high level of intensive outpatient care (e.g. assertive community treatment, case management services, high numbers of emergency assessments, partial hospitalization programs, etc). Whereas in other geographic areas, a CMHC may have greater numbers of less acute patients who mostly require a psychiatrist only for medication management services every few weeks to months, and less numbers of patients requiring other, more intensive services.

In an effort to better define the role of the psychiatrist in the community mental health center, as well as develop reasonable time allocations for physician services, a panel of psychiatrists was assembled under the direction of the Clinical Services Division of the Illinois Office of Mental Health. The panel members are the authors of this article. All members of the advisory panel are psychiatrists who practice at least part time in the public sector either in an inpatient setting, an outpatient setting, or both. This panel focused on developing appropriate guidelines for direct and indirect clinical services provided by psychiatrists in the community mental health center setting. Included were clinical expectations for psychiatrists and attempts to accurately assess the amount of time required to fulfill these guidelines. Based on these determinations, an effort was further made to develop a formula which could aid in the estimation of psychiatrist time needed in CMHCs. Surprisingly, little has been written on this subject as literature review turns up very few current references. This project in Illinois was initiated to help stimulate thought in regards to the appropriate numbers of psychiatrists needed in the community mental health centers, and to determine what is the best use of their time and expertise—with the ultimate goal being the provision of higher quality, comprehensive services to the mentally ill patients served.

The first document produced was a set of guidelines focusing on the clinical expectations for psychiatrists treating outpatients in the community mental health center setting. It essentially defines the role of the CMHC psychiatrist in regards to psychiatric medication management, standards for treatment, and responsibilities of the CMHC on this issue.

The first product (Document 1) of this panel is as follows:

GUIDELINES FOR PSYCHIATRISTS PROVIDING DIRECT AND INDIRECT CLINICAL SERVICES IN THE COMMUNITY MENTAL HEALTH CENTER

DEFINITION

Clinical services provided by psychiatrists include comprehensive diagnostic assessment, and overall responsibility for quality follow up psychiatric care of outpatients in the community mental health center setting—in particular, the prescribing and monitoring of psychotropic medications for the treatment of psychiatric illness.

PURPOSE

—To diagnose and treat those mental illnesses and their accompanying symptoms which are known to respond to psychotropic medication

—To efficiently maintain stability and promote optimal levels of patient functioning through the utilization of psychotropic medication.

—To ensure that psychiatrist clinical services meet accepted community standards of practice.

—To ensure safe medication management by appropriate monitoring of patient symptoms and side effects, providing patient education, and appropriate medical follow up.

—To evaluate and monitor patients for the presence of physical illness which may impact psychiatric syndromes or affect the prescription of psychotropic medications.

—To regularly observe response, and adjust the psychotropic medications of those patients who have been diagnosed and initially treated in the inpatient setting, in order to prevent relapse and maintain clinical stability. Furthermore, help minimize utilization of inpatient services.

—To ensure adequate continuity of care between the

inpatient and outpatient settings.

ELIGIBILITY

—Individuals clinically appropriate for outpatient psychiatric services who may likely benefit from the use of psychotropic medication for the treatment of a psychiatric illness.

—Individuals who have been prescribed psychotropic medication in the inpatient setting and who have subsequently been referred to the outpatient agency.

SERVICE ELEMENTS

—An initial comprehensive psychiatric evaluation and periodic reassessment

—Prescription of psychotropic medication by a licensed physician (psychiatrist)

—Patient education regarding safe and effective psychotropic use.

—The ordering and monitoring of indicated baseline and follow up laboratory tests (blood work, EKG, MRI, EEG, for example.)

—Referral to adjunctive therapies which are felt to promote the overall mental and physical health of the patient

—Communication with other treatment team members regarding the comprehensive treatment of the patient.

STANDARDS

Assessment;

—The initial comprehensive psychiatric evaluation includes the following;

-Identifying information of the client
-Chief Complaint
-History of Present Illness
-Medication History
-Past Psychiatric History
-Medical, Social, Family and Developmental History as clinically relevant
-Substance Abuse History
-Complete Mental Status Examination
-DSM IV Diagnoses
-Treatment Recommendations/Plan

—At the time of discharge from an inpatient psychiatric unit, patients will have a scheduled appointment at the appropriate mental health clinic for outpatient evaluation for medication management services. This appointment will be with a licensed physician (psychiatrist), and will be no more than 5 (five) working days after the discharge date from the inpatient facility.

—The physician will recommend a thorough physical exam annually, and follow up as indicated for any patient receiving psychotropic medication.

—If clinically indicated based on the DSM IV diagnosis of the patient, the psychiatrist will recommend, in accordance with accepted standards of practice, that the patient take psychotropic medication.

Prescribing psychotropics;

—The psychiatrist will provide written information regarding risks and benefits of the psychotropic medications prescribed (including the risk of tardive dyskinesia with antipsychotic medication) in accordance with the Mental Health Code in Illinois. Furthermore, this patient education regarding psychotropics will be documented by the physician in the patient's medical record.

—DSM IV diagnoses and treatment plans must be clearly described in the patient's medical record, including specific outcome variables to be monitored regarding response/non-response to treatment with psychotropic medication.

—A medication log should be part of the patient's medical record, and must include;
a list of the medication prescribed, dosage of each, directions for use, amount prescribed, number of refills, and signature of prescribing psychiatrist. The medication log should reflect renewal of, or any change, in the medication regimen, and should be up to date.

—When pharmacological management includes the need for laboratory evaluation, this must be adequately explained and documented, and carried out in accordance with existing community medical standards of practice for the medications involved. For example, at a minimum, for the following medications this would include;

For lithium — lithium level, thyroid function tests and kidney function tests at least every 6 to 12 months.

For valproic acid (Divalproex Sodium) — CBC with differential, liver function tests and valproic acid level at least every 6 to 12 months

For carbamazepine — CBC with differential, liver function tests, carbamazepine level at least every 6 to 12 months

—The rationale for polypharmacy, when employed, must be clearly documented in the patient's medical record, explaining the indications for each psychotropic prescribed. Polypharmacy is defined as the prescribing of two or more psychotropic medications of the same class.

—If dose ranges or frequency of administration prescribed are outside the normal adult therapeutic standards (high or low), a clear rationale must be documented in the client's medical record.

Follow Up Management/Periodic Reassessment;

—The community agency must make arrangements to have a psychiatrist available on a 24 hour basis to assist patients with urgent questions or concerns regarding medication effects.

—Unless clinically appropriate and clearly documented otherwise in the medical record, patients being prescribed psychotropics must be seen at a minimum of once every three (3) months.

—Follow up psychiatrist evaluations (Periodic Reassessment) must include the following;

- -Relevant mental status examination
- -An assessment of medication compliance
- -Progress/deterioration in regards to specific outcome variables described in the patients treatment plan
- -Evaluation of potential medication side effects (including tardive dyskinesia)
- -The follow up, or initiation of, any diagnostic procedures (labs, X-rays, etc). The rationale for each procedure must be documented.
- -Documentation of any alteration, or continuation of, the treatment plan.

—Documentation of the outcome of referrals to adjunctive therapies or medical consultations, and any relevant communication with the treatment team.

—Contact with a clinic psychiatrist regarding patient care services outside of the appointment setting, need be documented in the patient's medical record (phone calls, for example.)

—If a determination is made that psychiatrist services are to be suspended or terminated, the reasons for this must be clearly documented, including indications or conditions for reinstatement.

SPECIAL CONDITIONS

—Compliance with these standards must be monitored by a designated physician at each community mental health agency through an annual peer review . This review will consist of a sampling of each clinic psychiatrist's medical records. Deficiencies need be brought to the attention of the prescribing psychiatrist for correction. Documentation of this review must be readily available.

As one can see, the direct care role of the psychiatrist was still essentially defined as the performance of diagnostic assessments (new patient evaluations), and medication management services (follow up). However a more thorough understanding of the time requirements, actual service elements involved, and the complexity of the psychiatrist's role is outlined. Also, a necessary quality assurance process is suggested which must be the function of a psychiatrist(s) to develop and monitor. The guidelines, to some, may seem lofty, but are felt reasonable, attainable and appropriate for quality patient care.

Section II.

After the guidelines were determined, an effort was made to develop a method or formula to assist in estimating the amount of psychiatrist time needed to appropriately staff community mental health centers. Time parameters for "medication management" visits as well as new patient evaluations were determined by the panel members based on the requirements of the guidelines for medication related services previously mentioned. In addition, since each CMHC is different in respect to their patient "make up", any formula employed would need take into consideration the various numbers of patients who require different levels of service. For the purposes of this formula, we divided patients into one of five levels of acuity (designated as A through E) based exclusively on the amount of time felt

needed by a psychiatrist to adequately manage their care. This was determined by taking into consideration the previously developed clinical guidelines for CMHC psychiatrists, and the frequency of psychiatrist visits felt required. The standard was set such that frequency of psychiatrist visits should be no less than once every three months.

This way of determining the level of "acuity" for various patients obviously permits some objectivity on the part of the individual(s) making this decision. It is also imperative that the respective CMHC administration really "knows" its patient population well, especially in regards to services needed and growing trends in the community. This is all the more reason that strong psychiatric leadership is required in community mental health centers. It is recommended that the determination as to what level of acuity level best describes a particular patient should be the job of the psychiatrists in the CMHCs. In fact, this whole process could well be incorporated into the quality assurance role of a designated psychiatrist Medical Director.

A second task of this panel was to then construct a relatively simple, but quantitative method which could help estimate a satisfactory psychiatrist staffing pattern for community mental health centers. At a minimum, it should serve to arrive at a suggested amount of psychiatrist time needed to provide quality patient care by fulfilling all the standards set in the previous guidelines.

The following formula and its explanation (Document 2) resulted;

Estimation of Psychiatrist Time Required for Community Mental Health Centers

This method of estimation is based on the following principles;

—No more than 75% of the psychiatrists time is direct care, and approximately 25% is non-direct (staffings, supervisory, administrative)

—A reasonable amount of time is needed by psychiatrists to perform the tasks required for direct patient care issues. Parameters determined by the committee are as follows;

For each outpatient medication management/follow up evaluation visit — 30 minutes
For each new patient evaluations (intake evaluations) — 60 minutes

These time allotments take into consideration all the following tasks of the psychiatrist which constitute direct care hours—patient evaluation/ examination as outlined by the guidelines for clincial services of the psychiatrist (Document 1) , medical record review, review of laboratory data and any medical consultation, discussion with family members/significant others pertinent to the case, treatment plan reviews, emergency psychiatric consultation and assessment, patient education, patient groups. These time parameters are for all levels of patient types, i.e., including assertive community treatment (ACT), case management services, partial programs, etc.

—Since all community mental health centers have somewhat different patient mixes and services (for ex., different %'s of ACT patients, varying numbers of new patient intakes, different numbers of emergency assessments, etc.) the estimation of the psychiatrist time also need be based on the number of patients on a psychiatrist's case load from various designated levels of acuity (category). The acuity level is determined by the frequency of outpatient visits required, as determined by the psychiatrist.

Five levels of acuity of CMHC patients and the direct psychiatrist time required per week for each patient in that category;

A. New evaluation -- defined as the first outpatient visit to a psychiatrist in that CMHC
Requires 60 minutes/patient/week

B. High acuity patient — defined as a patient who need be seen by a psychiatrist at least every 2 weeks (or more frequent) for follow up as determined by the treating psychiatrist
Based on 30 minute visit, this averages to at least 30min./2weeks = 15 minutes/patient/week

C. Moderately high acuity patient — defined as a patient who need be seen at least every 2 to 4 weeks as determined by the treating psychiatrist.

This averages to at least 30min/4 weeks = 7.5 minutes/patient/week

D. Moderate acuity — defined as a patient who requires to be seen at least every 4 to 8 weeks as determined by the treating psychiatrist. This averages to, at least, 30min/8weeks = 3.75 minutes/patient/week

E. Low acuity — defined as a patient who need be seen at least every 8 to 12 weeks as determined by the treating psychiatrist. This averages to at least, 30min/12weeks = 2.5 minutes/patient/week

To estimate the total amount of psychiatrist time needed based on these parameters (direct and non-direct time), utilize the following formula;

$$\frac{(A \times 60) + (B \times 15) + (C \times 7.5) + (D \times 3.75) + (E \times 2.5)}{(.75) \times 60}$$

= Total Amount of Psychiatrist Time Needed in hours/Week

Some explanations;

This formula can be used to estimate the total number of psychiatrist hours required to meet the needs of a given community mental health center based on the CMHC's patient population OR it could serve to assess if a specific psychiatrist is contracted for a sufficient number of hours to meet the demands of his/her current individual case load.

A + B + C + D + E = should reflect the total number of patients served by the CMHC (or the total number on a given psychiatrist's case load)

(A x 60) + (B x 15) + (C x 7.5) + (D x 3.75) + (E x 2.5) = should reflect the amount of direct care psychiatrist time required per week (in minutes)

(.75) factors in the principle that 75% of psychiatrist time is direct care (face time spent with the patient), and 25% is non-direct (staffing, supervisory time, consulting to other CMHC staff, etc.)

60 converts minutes to hours

This formula takes into consideration different patient populations of various community mental health centers, based on reasonable estimations of psychiatrist time needed to meet the tasks required by the psychiatrist.

Finally, it is strongly recommended that each community mental health center has a Medical Director to oversee program development, handle clinical administrative issues, peer review, physician evaluations, AND the assessment of psychiatrist time needed at the CMHC. This should require several hours per week, possibly up to a half time position (20 hours/week)

Section III:

The work of this panel and the development of guidelines for clinical services by psychiatrists and an estimation of psychiatrist time needed in the mental health center setting, reveals a number of important issues.

When the formula was subjected to current real life practice situations, it seemed to be of merit. Eleven (11) psychiatrists who work in CMHCs from four different states (Illinois, Indiana, Florida and Michigan) were surveyed. Of these 11, six felt that their specific CMHC employment situation allowed adequate time for the size and complexity of their respective caseloads. When their caseloads were categorized into acuity levels as described, and placed into the formula, all six psychiatrists found that their actual contracted work hours fell within ± 1.3 hours of that calculated. The second group— which consisted of the other five psychiatrists from the community mental health centers— all felt that they were overwhelmed by the numbers of patients they were required to see, and believed they had inadequate time to provide the necessary clinical care. When this group reviewed their caseloads, categorized them, and used this formula, a significantly different result was obtained. All five of these psychiatrists found that our formula determined their caseloads indeed required from 5 to 12 additional hours per week beyond what they were currently contracted. At least from the subjective reports of these 11 psychiatrists, it appears the formula may be useful.

Another factor of significant concern is the traditional role of the psychiatrist in many of the current community mental health centers. Psychiatrists have been used primarily as "the prescribers of

medication" and their expertise in regards to the development of programs, clinical administrative issues, and overall medical/psychiatric oversight for the outpatient clinics has not often been well utilized. Since most CMHCs are not under the leadership of psychiatrist administrators, they may tend to under appreciate or underestimate some of the clinical elements required to truly provide the highest quality care to mentally ill outpatients. Although still focused mainly on medication management services, our guidelines accentuate a broader range of responsibilities and duties incumbent upon a psychiatrist who attempts to appropriately manage outpatients in CMHCs. The guidelines further advocate for the concept of a designated Medical Director (psychiatric M.D.) in the CMHC setting.

It is felt by our panel, that community mental health centers that have an identifiable, qualified psychiatrist administrator (Medical Director), function in a more efficient manner, provide more comprehensive services, offer better communication with other mental health care providers, have appropriate clinical expectations for their medical staff, and overall tend to provide higher quality patient care. The benefit of good medical leadership appears clear.

In summary, many community mental health centers have a significant shortage of qualified psychiatrists currently working in their system. This shortage is likely due to a variety of factors including burnout due to excessive direct care patient loads, lack of funding on the part of the community mental health centers, relatively low compensation in some CMHCs for psychiatrists, and perhaps a general lack of interest for doing this type of "public sector" outpatient work on the part of many qualified psychiatrists. Yet, with many good psychiatrists finding the private practice climate less appealing in recent years, the public sector may now—more than ever—be poised to have an opportunity to recruit more quality psychiatric physicians into the community mental health systems of care.

The purpose of this article is to promote the concept of comprehensive medical leadership by psychiatrists in the community mental health centers in regards to clinical management, program development, and the fiscal decision making of the institution. This article suggests not only do we need more qualified psychiatrists in the community mental health center setting, but we need greater involvement of psychiatrists in leadership positions. Whereas direct clinical care is undoubtedly one of the most important things a good psychiatrist can contribute to a community mental health center, the value of competent psychiatrists in administrative leadership roles cannot be minimized.

Though not without limits, these guidelines, standards, and the formula outlined in this article may well have some value in the CMHC setting. This information could be just one way to assist in determining the necessary psychiatrist staffing required to provide the best possible care at a given CMHC. Furthermore, it could also serve as a tool in negotiations between psychiatrists and the community mental health centers that employ them.

Further review and other means to assess the needs of CMHCs in respect to psychiatrist involvement must be explored in order to adequately address this very important public mental health issue.

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