# Columbia University's Fellowship in Public Psychiatry

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**In 1981 the fellowship in public psychiatry was established at New York State Psychiatric Institute and Columbia University College of Physicians and Surgeons to provide subspecialty training for psychiatrists who plan careers in the public sector. Ten one-year postresidency fellowships are awarded annually. The fellowship consists of supervised work and didactic experiences focused on the clinical modalities most effective in public mental health services and the managerial skills that the psychiatrist must possess to make those services work well. Fellows work three days a week at collaborating public-sector agencies throughout the New York metropolitan area. The curriculum includes an academic seminar, which gives fellows an introductory overview of major topics in public psychiatry; an organizational practicum, which is an exercise in management principles and practices; an evaluation practicum, which addresses the theory and practice of program evaluation; and an applied seminar, organized as a cycle of clinical, administrative, fiscal, and evaluation presentations in which each fellow applies the concepts learned in the other seminars to his or her field placement work. Of the 75 fellows who have graduated from the program, only six have chosen to leave the public arena. Nearly all work full time in the public sector, where more than half hold management positions. More than three-fourths hold academic appointments at medical schools in the area in which they are working as public psychiatrists. (*Psychiatric Services* 47:512–516, 1996)**

The mental health system in the United States is supported primarily by public funds. Of the approximately $23 billion spent by all mental health organizations in 1988, 73 percent came from public funds (1). General hospitals—mostly not-for-profit institutions—received 59 percent of their funding from public sources. In fact, private for-profit psychiatric hospitals, in which 62 percent of funding came from client fees (including private insurance), constituted the only category of mental health provider in which public funding accounted for less than 50 percent of all funding.

Despite the heavy reliance on public funding, the cherished national tradition of attempting to minimize the role of government in personal affairs is especially noticeable in mental health services. A relatively small percentage (35 percent) of the services funded by public money are provided in what most people think of as public institutions: state, municipal, and federal hospitals and clinics (1). The remaining 65 percent of public funding is funneled to not-for-profit institutions to provide public services, even though many patients and providers do not think of these services as public. In fact, many programs provided by private not-for-profit hospitals and agencies can reasonably be called public-sector programs.

The public-sector mental health system is appropriately defined as constituting agencies, programs, and services financed primarily by public funds with mandates to serve populations with social as well as psychiatric needs. These populations consist of people with severe mental illness and other major social and psychiatric problems such as substance abuse and homelessness. Members of poor urban and suburban minority groups also constitute a population served by the public-sector system. These groups cannot, or do not, purchase services directly but rely on public funding. This public money inevitably comes with strings attached, such as contracts for specific services to mandated target populations, certification and accreditation standards, and mechanisms for ensuring fiscal accountability.

Professionals who manage and work in these agencies and programs need to know what kinds of services will best fulfill the mandates that justify these public expenditures, how to create and maintain organizations to deliver these services, and how to deal with the myriad requirements incumbent on spending public funds. Godard and others (2) have noted, "To

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be a successful public psychiatrist requires an ability to work within a complex public system that includes a community with its multiple agencies, a hospital with its bureaucracy, and a government with its mandates and limitations. In the 1990s, it also requires competency in the treatment of persons with severe and chronic mental illness."

This paper describes a fellowship program that trains psychiatrists for leadership roles in the public sector. The role of the public-sector psychiatrist is outlined, and the program's curriculum, as well as its ability to recruit and retain psychiatrists in the public sector, is described.

## The role of the psychiatrist in the public sector

As the locus of care for most psychiatric patients has moved from the hospital to the community, psychiatric leadership has not kept pace with the expansion of services. Outpatient programs and, increasingly, hospitals have seen leadership pass first from psychiatrists to other mental health professionals and, more recently, to professionally trained management (nonclinical) personnel (3).

Many would say that this change is inevitable. There are too few psychiatrists, their services are needed to provide direct care and to prescribe medications, and they require higher compensation than nonclinical management personnel. Others would say that the change is desirable. Psychiatrists rarely have the training in management or finance necessary to run complex organizations, and medical and psychiatric training, which emphasizes treatment of the individual patient, may interfere with the psychiatrist's ability to make decisions that affect large groups of people (4).

However, psychiatrists possess certain characteristics that make them well suited for leadership of psychiatric programs. Management personnel may know how to economize, but without effective clinical leadership, programs often flounder without any direction other than that dictated by budget constraints. Furthermore, because psychiatrists have special legal responsibilities for patient care, some form of leadership responsibility inevitably seeks them out (5). If the director of a mental health agency or program is not a psychiatrist, a psychiatrist is generally in the position of medical (or clinical) director (6).

These leadership positions are too often filled by inexperienced psychiatrists with no special management training during residency or fellowship. Despite the availability of guidelines for the role of medical director developed by the American Psychiatric Association (7) and currently being revised (8), these job descriptions "may have little to do with how the psychiatrist is really spending his or her time" (9). Lacking guidelines or special training, most psychiatrists do not really know how to cope with the demands or to fully utilize the opportunities that accompany leadership responsibilities. They are thus forced to learn through experience, and many fall by the wayside, discouraged and demoralized.

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In addition, psychiatric training has not adequately adjusted to the shift of psychiatric care to the community but has remained largely tied to its funding base in hospitals (10,11) Accreditation guidelines for psychiatric training do not require specific training in rehabilitation approaches for chronic psychiatric illnesses (12), and consequently most programs do not provide adequate training in psychiatric rehabilitation (13).

Santos and associates (11) identified an encouraging shift in emphasis of psychiatric training toward the community: "While reduced revenue from inpatient hospitalizations will create a problem for the financing of graduate medical education, it also presents an opportunity for updating the training curricula." Indeed, they comment that such a shift has been going on in South Carolina for the past ten years, resulting in an increase from 26 to 58 percent in the number of graduates taking public-sector jobs in the first year after residency.

However, it is too often reported that even programs attempting to train psychiatrists to work in the public sector find that their graduates do not maintain this commitment after graduation. Extensive training in public psychiatry at the residency level has been reported in Oregon (2), Maryland (14), and Colorado (15), in addition to that noted in South Carolina. These programs have experienced mixed results. At best, graduates remain for several years in the public sector before deserting for what they hope will be more lucrative areas of private practice (14). Even worse, less ambitious graduates remain in the public sector, primarily dispensing medication, immobilized and disaffected.

## The fellowship in public psychiatry

The fellowship in public psychiatry at New York State Psychiatric Institute and Columbia University College of Physicians and Surgeons was created in 1981 by a group of professionals who had worked together in the innovative social and community psychiatry division of the Albert Einstein College of Medicine (16–19). The fellowship was conceived in the belief that providing psychiatrists with the knowledge and skills necessary to assume leadership roles in the public sector is the most effective way to combat problems of recruitment and retention. By maintaining a stake in running the professional organiza-

tions in which they serve, psychiatrists can exercise enough control over their professional lives to feel fulfilled and able to flourish in public-sector careers.

The fellowship represents a public-academic liaison between New York State Office of Mental Health and Columbia University. The goal of the office of mental health is to facilitate recruitment and retention of high-caliber psychiatrists to serve as leaders in the provision of services in the public sector and to redirect training resources to preparing psychiatrists for the new duties and responsibilities of community-based care.

*Overview of the training program*

Ten one-year postresidency fellowships are awarded annually to qualified candidates who plan careers in public psychiatry. The fellowship consists of supervised work and didactic experiences focused on the clinical modalities most effective in public mental health services and the managerial skills that a psychiatrist must possess to make those services work well.

Fellows spend three days a week working in a public mental health service organization selected as a training site, where they serve as members of interdisciplinary treatment teams. They spend the other two days a week in seminars, supervision, and consultation with the fellowship faculty at the headquarters of the fellowship at New York State Psychiatric Institute. In these seminars, the fellows establish collegial relationships with other fellows, faculty, and guest speakers. These relationships endure after the fellows graduate from the program, forming the basis of the ongoing professional support that is essential in the career of the public psychiatrist. Each fellow meets weekly with a faculty preceptor, who oversees all aspects of the fellow's program.

**Field sites.** The fellowship has developed a list of community service agencies from which fellows select a training site. Alternative sites proposed by individual fellows with special interests are considered. The purpose of the field assignment is to provide fellows with in-depth knowledge of the operations of a particular mental health service, its target population, its problems, and the contributions made by psychiatrists who serve as clinician-managers.

In conjunction with a supervisor, who is a senior professional at the training site, each fellow negotiates a contract to perform certain duties. In most cases the supervisor is the facility director. The duties usually include participation on a clinical team and a combination of direct patient care, supervisory consultation, and administration.

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The kinds of programs that have served as training sites in recent years include continuing day treatment, intensive case management, comprehensive psychiatric emergency programs, intensive psychiatric rehabilitation programs, mobile and outreach teams, programs for mentally ill chemical abusers, supportive housing and crisis housing programs, drop-in centers for homeless persons, services to families with HIV-infected members, consultation-liaison in ambulatory medical clinics, services to victims of acute and long-term trauma, services for foster care programs, and specialized services for Hispanic and Asian Americans.

**Training curriculum.** Five one-and-a-half-hour weekly seminars continue throughout the year. They include the academic seminar, the organizational practicum, the evaluation practicum, guest speaker presentations, and the applied seminar.

The academic seminar is an introductory overview of major topics in public psychiatry. The topics include the structure of public psychiatry in the United States, theory and practice (including model programs) in services for adults with severe and persistent mental illness, special populations (including minorities and those who are homeless or who have substance abuse problems or AIDS) and, increasingly, managed care in the public sector.

The organizational practicum is an exercise in management principles and practices. Didactic sessions cover organizational theory, leadership styles, management practices and strategies for public psychiatry, fiscal management, continuous quality improvement, regulatory standards, and personnel. These didactic presentations are integrated with case studies presented by alumni who currently hold management positions. In addition, one alumnus presents an ongoing monthly case study each year. These presentations are structured as organizational consultations in which fellows are asked to analyze and make suggestions to solve a specific management problem and are then told how the presenter dealt with the situation. This approach gives the fellows a unique opportunity to observe how alumni are implementing the ideas taught in the fellowship.

The evaluation practicum is an exercise in the theory and practice of program evaluation and evaluation research. Fellows are introduced to the concepts of program and outcomes evaluation, qualitative evaluation, research design, and data management.

Guest speaker presentations cover areas of interest in public policy, delivery of services, working with families and consumer advocates, specialized clinical work, and research. Fellows make monthly field visits to public-sector programs of special interest.

The applied seminar is perhaps the core educational experience of the

*Table 1*

Types of facilities in which 72 alumni of the fellowship in public psychiatry of New York State Psychiatric Institute and Columbia University College of Physicians and Surgeons are currently employed

| Type of facility | N | % |
|---|---|---|
| Public sector | 66 | 92 |
| State hospitals and clinics | 14 | 19 |
| Municipal facilities | 10 | 14 |
| Public not-for-profit hospitals and agencies | 26 | 36 |
| Community mental health centers | 6 | 8 |
| Federal (Veterans Affairs and military) | 5 | 7 |
| Private facilities with public contracts | 5 | 7 |
| Private sector | 6 | 8 |
| Private hospitals | 3 | 4 |
| Private practice | 3 | 4 |

training curriculum. It is organized as a cycle of clinical, administrative, fiscal, and evaluation presentations in which each fellow applies the concepts learned in the other seminars to his or her field placement work. One of these presentations involves designing, pilot testing, and presenting a program evaluation that examines an aspect of the service system at the fellow's placement site. Throughout the seminar, each fellow is supported in addressing the question of how he or she would organize, supervise, and evaluate the given service. This question has as much practical as academic importance, because the field placement frequently turns out to be the first year of a permanent position at that agency.

### *Funding*

Originally, all fellowship positions were fully funded by New York State Psychiatric Institute. Within the first few years, other state facilities began providing funding for fellows placed at those facilities. Starting in 1987, nonstate agencies have sometimes provided full funding to support trainees placed there. Nonstate participants have included an increasing number of both municipal and not-for-profit hospitals and community services.

In 1992, in response to a growing pool of highly qualified applicants coupled with state funding cutbacks, the placement sites were asked to provide one-third funding for fellows placed with them. In 1995 the fellowship asked some sites to provide two-thirds of fellows' stipends, and in 1996 most agencies will provide this level of funding. The agencies are still getting a bargain—three days a week of work for approximately the cost of a half-time psychiatrist. The willingness of these hospitals and agencies to fund fellowship positions from their own hard-pressed budgets is a strong testimony to the value they see in collaborating with the fellowship program. Supported by these funding mechanisms, the size of fellowship classes has increased over the past five years from six to ten fellows.

## Effectiveness of recruitment

A major premise of the fellowship is that there is a pool of highly qualified junior psychiatrists who recognize the need for specialty training in public-sector psychiatry. The experience of the fellowship has strongly confirmed this premise. More than half of the fellows over the past five years have been chief residents at major teaching programs. The fellowship has trained eight graduates of the American Psychiatric Association's Mead Johnson fellowship program in public psychiatry.

We are particularly proud of our ability to recruit women and minorities. Of the 75 fellows who have graduated from the program 34 (45 percent) have been women and 28 (37 percent) have been minorities, compared with 23 and 30 percent, respectively, of APA members identified as public psychiatrists in the most recent APA survey, conducted in 1988–1989 (20). These proportions also compare favorably with those reported for faculty appointments in psychiatry among U.S. medical schools—32 percent women (41 percent at junior ranks) and 18 percent minorities (junior ranks not reported) (21).

In recent years the fellowship has attained national prominence. One sign of this recognition is an increasing number of applicants from beyond the New York metropolitan area. Applications have been received from psychiatric residents in New Jersey, Pennsylvania, Rhode Island, Massachusetts, Washington, D.C., Virginia, North Carolina, Mississippi, Texas, New Mexico, California, and Oregon.

*Table 2*

Responses to 1992–1994 surveys of alumni of the fellowship in public psychiatry[1]

| Variable | N reporting[2] | Affirmative responses | |
|---|---|---|---|
| | | N | % |
| Works in public sector | 72 | 66 | 92 |
| Works at site of field placement[3] | 57 | 27 | 47 |
| Holds management position | 71 | 39 | 55 |
| Holds academic appointment | 69 | 57 | 83 |

[1] Of the 75 fellowship alumni, 34 are women and 28 are minorities.
[2] The number reporting varies because not all respondents answered every question.
[3] Based on 57 alumni who were still in the New York metropolitan area at the time of the survey

## Effectiveness of retention in the public sector

For the past three years, the fellowship program has sent yearly questionnaires to all fellowship alumni. As of June 1994, a total of 75 fellows had graduated from the program. Sixty-six of the 75 (88 percent) have responded at least once to the annual survey, and we have been able to learn the primary work activity of all but three of the remaining nine (one of whom died). Thus an unusually complete picture of the current profile of graduates' professional activities is available.

Table 1 shows the current primary work setting by type of facility of the 72 graduates for whom we have information. These data show that 66 of the graduates (92 percent) work in public settings. Thus in the 14 years of the program's existence, only six of the graduates (8 percent) have chosen to give up the public arena as the principal focus of their professional effort. This retention rate is in dramatic contrast to that found in the 1988–1989 survey of APA members

(20), in which 48 percent identified private practice as their primary work setting.

Fellows maintain a strong commitment to their field placement agencies. As Table 2 shows, of the 57 alumni who have remained in the New York metropolitan area, 27 (47 percent) are in the agency in which they did their field placement.

Of the 71 alumni for whom we have sufficient information, 39 (55 percent) reported that they are in management positions in the public sector. In addition, the vast majority of alumni work full time in their primary work setting. Sixty-six alumni reported the number of hours they spent in their primary working setting; the mean number of hours per week was 36.

As Table 2 also shows, the graduates have continued to bridge the gap between academic and public psychiatry in that 83 percent have academic appointments at medical schools in the area in which they are working as public psychiatrists. Several alumni serve as voluntary faculty in the fellowship program. They give lectures to fellows or serve as field placement supervisors. This process has allowed alumni to share experiences with their younger colleagues and keep the faculty abreast of changes in the public system that should be addressed in the teaching program. In addition, the faculty remains in contact with alumni through reunions and consultations (especially at career junctures). Alumni report that this active network is a significant factor sustaining many of them in the public sector.

## What's ahead?

The public psychiatry fellowship has been highly effective in recruiting and retaining psychiatrists to fill leadership roles in the public sector. The increasing number of applicants indicates that they believe this training will best prepare them for the future practice of psychiatry. Despite the increased interest in this type of training, the number of similar fellowships around the country is remarkably meager. The few that have been created have tended to lose funding after several years, which was the fate of even well-known programs at Albert Einstein College of Medicine and Massachusetts General Hospital (3). Many programs offer only one position in administrative or community psychiatry, functioning more as mentorships than fellowships.

An interesting new development has been collaborations in which fellows have been jointly enrolled in the public psychiatry fellowship and new public-sector psychiatry fellowships at other academic institutions. This collaboration supports the development of other fellowships, because the academic curriculum and expertise developed by the faculty of the public psychiatry fellowship is highly regarded by other institutions providing specialized public-sector training. Collaborations have taken place with Bellevue Hospital–New York University (1994–1995 and 1996–1997) and Mt. Sinai Medical Center (1995–1996). Several people have contacted the fellowship from around the country for consultation in starting new programs.

The fellowship in public psychiatry clearly fills an important need for specialty training in public-sector psychiatry. We hope this description of the program encourages the development of similar fellowships. ♦

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