

Demographic Analysis of Members of the American Association of Community Psychiatrists

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ABSTRACT: This study examines which issues public psychiatrists perceive as having most impacted their careers over the past five years and whether this impact was experienced differently by psychiatrists in varying regions of the country. The author sent a questionnaire to all members of the American Association of Community Psychiatrists in clinical practice for at least five years. Seventy-one percent (344 of 482) responded. As expected, respondents were generally negative about how economic factors have impacted their professional lives. This impact, however, was experienced very differently depending on which region of the country the psychiatrist was working.

KEY WORDS: public psychiatrists; medical directors; changing role; regional differences.

INTRODUCTION

In Kennedy's landmark 1963 Community Mental Health Centers (CMHC) Act, it was assumed that CMHCs would be run by psychiatrists, as had the state hospitals before them. But, as has been often noted, the proportion of CMHCs run by psychiatrists dropped rapidly from 55% in 1971 to 26% in 1977 (Ribner, 1980), and 8% by 1985 (Knox, 1985). Notwithstanding this shift, some centers recognized the need for psychiatric

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oversight and began to appoint psychiatrists as medical directors. However, the position of medical director is rarely mentioned in the early literature of CMHCs. In the APA Report of the Task Force on Community Mental Health Programs published in 1982, there is no reference to the position of medical director, even in a discussion of staffing (Watson, 1982). A number of articles discussing the roles of psychiatrists in CMHCs either don't refer to the position of medical director at all (Diamond, Cutler, Langsley, & Barter, 1985), don't refer to the title "medical director" even when describing the responsibilities (Diamond, Stein, & Susser, 1991), or use other titles such as "administrative directorships filled by psychiatrists" (Langley, & Barter 1983) when describing leadership roles for psychiatrists. A number of articles make pleas to reverse the tide of the decreasing number of psychiatrists running CMHCs (Knox, 1985; Watson, Bowman, & Jepson 1982; Vaccaro & Clark 1987) without referring to the role of medical director as a possible solution to this problem.

There was a relative re-emergence of psychiatric leadership in Community MH services in the mid-1980s. Diamond, Stein, and Schneider-Braus (1996) note that several factors that have led to this development, including an increasing focus on treatment of persons with serious mental illness and insistence by state agencies and third-party payers that psychiatrists supervise treatment provided by non-medical staff (pp. 89 and 90). The American Association of Community Psychiatrists (AACP) was founded in 1984, with the explicit mandate to "establish and define the role of psychiatrists in community programs." (Breakey, 1996). In 1986, the AACP developed Guidelines for Psychiatric Practice in CMHCs (AACP Guidelines, 1995). With the approval of these guidelines by the APA in 1991 (Guidelines, 1991), it became the official position of the APA that all mental health centers should have medical directors with clinical leadership roles (Clark, 1991). By the early 1990s, Diamond et al., (1996) found that 142 of 214 (66%) CMHCs responding to their survey reported having job descriptions for a medical director.

A previous survey of members of the AACP was conducted in 1998 (Ranz, Stueve, McQuiston, 2001). In that survey, members were asked to indicate their job type as staff psychiatrist, program medical director (as defined in Ranz & Stueve, 1998) or agency medical director, breadth of supervisory responsibility as medical staff only, medical and clinical staff or all staff, and control over budget (none, input, own budget). The questionnaire detailed 16 tasks conceptually divided into three groups: direct service, clinical collaboration and administration. Respondents were asked to report how frequently they performed each of the 16 tasks.

The survey was sent to 479 active members of the AACP, and 289 (60%) responded. The average age of the respondent sample was 48, with 71% males, 89% Caucasians. Looking at job type: 40% were agency medical directors, 23% program medical directors, and 31% staff psychiatrists. Among medical directors, breadth of supervisory responsibility was recorded as follows: medical staff only = 41%, medical and clinical staff = 31%, all staff = 28%. As expected, those who supervised medical staff only were significantly less likely to supervise non-medical staff than those who supervised medical and clinical staff. Control over budget was recorded as follows: 49% no input, 33% input, 18% own budget. Salary: Median salary was in the range \$100,000 – \$125,000. Agency medical directors performed significantly less direct service and significantly more administration compared to program medical directors.

METHOD

In this followup survey, conducted in 2002, we decided to broaden our field of inquiry from specific jobs (as in the previous survey) to the field of public psychiatry in general. The purpose of this survey was to assess which issues have most impacted public psychiatrists in the past 5 years. Respondents were asked to report job type, breadth of supervisory responsibility and control over budget as above. They were also asked how many hours per week they work in hospital or community settings. Once again they were asked to report their salary range, and also how much their salary had changed in the past 5 years. The questionnaire further listed 22 items conceptually divided into 6 groups: (1) scientific and clinical activities, (2) economic developments, (3) organizational changes, (4) information systems, (5) advocacy and (6) changing populations (for individual items within each domain, please contact the author). In this survey, respondents were asked to report how much change they had experienced with regard to each item over the past 5 years. They were also asked to assess the impact each item had had on their professional life during that 5 years period. Finally, they were asked to give a single rating assessing the overall impact of all the changes listed.

The survey was distributed to 650 current AACP members. Of these, 78 were early career psychiatrists, who were excluded because they did not have 5 years experience in the field. In addition to the early career psychiatrists, a variety of other members were also excluded based upon information they provided to us (e.g., nonphysicians, not doing clinical work or retired) or because we were unable to contact them (i.e., the directory information was incorrect). That left an available sample of 482 members. Of these, 71% (344 of 482) responded. To get this high response rate, it was necessary to make up to 5 contacts per individual, as described in the companion article "Public Psychiatrists' Perceptions of Changes over the Past 5 years." That article reports the results of this survey with regard to how program and agency medical directors differentially experienced the changes over the past 5 years. This article will focus mainly on demographic and regional differences. Regions, as used in the AACP are as follows: New England, New York, Mid Atlantic, South East, North Central, West and California.

RESULTS

The average age of respondents to this survey is 52. Note that with early career psychiatrists excluded, the sample is 4 years older, as would be expected because the survey was conducted 4 years after the previous survey. Males constitute 67% of respondents, and Caucasians 81% (4% fewer males, 8% fewer Caucasians compared to previous survey). Respondents live in 41 states plus the District of Columbia, but NY (14%) and CA (10%) have by far most number of members.

Looking at job type, 32% of respondents are staff psychiatrists, 25% program medical directors and 43% agency medical directors. There are thus fewer staff psychiatrists and more program and agency medical directors compared to the 1998 survey, but the differences are not significant. Among PMDs and AMDs, breadth of supervisory responsibility is reported as follows: medical staff only = 40%, medical and clinical staff = 36%, all staff = 23%. There are thus somewhat more supervisors of medical and clinical staff and fewer supervisors of all staff compared to the 1998 survey, but these differences are also not significant. Control over budget is reported as follows: 46% no input, 41% input, 14% own budget. This breakdown shows somewhat more respondents having input, somewhat fewer respondents having their own budget, but again these differences are not significant.

Regarding auspice of agency, 44% of respondents work in nonprofit agencies, 34% state, 18% municipal, 4% for-profit and 1% federal. Respondents work an average of 22 h per week in community based organizations (CBOs), 7 h per week in hospital inpatients settings and 6 h per week in hospital outpatient programs. Agency medical directors are significantly more likely than program medical directors to work in CBOs, while program medical directors are significantly more likely than agency medical directors to work in hospital inpatient or outpatient settings.

The median salary is in the range \$125,000 – \$150,000 up from \$100,000 to \$125,000 range in the 1998 survey. Salary is significantly associated with job type (agency medical directors > program medical directors, $p = .009$; program medical directors > staff psychiatrists, $p = .039$) and is correlated with years at current agency ($p = .004$), but not years at current job.

Women are significantly younger than men (47 vs. 54, $p = .016$). They have a significantly lower salary (\$132,500 vs. \$ 147,500, $p = .003$) but report slightly higher salary change (ns). In a regression

analysis, women have significantly lower salary and are secondarily significantly younger, but these two effects are relatively independent of each other. Women are slightly more likely to fill program medical director positions, and less likely to fill agency medical director positions, but the difference is not significant. Women report significantly less overall change ($p = .014$), and report slightly lower impact.

Noncaucasians are older ($p = .085$) and slightly more likely to be female. Noncaucasians report greater total change ($p = .087$). There is no difference regarding salary, salary change, overall impact, job type, breadth of supervision or control over budget.

Regional Variations

Overall change and overall impact is not associated with region. But economic changes vary significantly by region ($p = .05$). The highest changes are reported in the Mid Atlantic region, and the lowest in the North Central region. Managed care changes vary significantly by region ($p = .000$). The highest are reported in Mid Atlantic followed by the West. The lowest are reported in NY, followed by North Central. Mergers vary significantly by region ($p = .006$); they occur most frequently in New England and least frequently in NY.

Salary is significantly associated with region ($p = .008$). North Central reports significantly higher salaries compared to the West. Salary change is also significantly associated with region ($p = .023$). California reports significantly higher salary increase compared to New England.

Gender is not significantly associated with region, but NY has highest proportion of women (58%) and California the lowest (17%). Noncaucasians are significantly associated with region ($p = .019$). The highest proportion are in California (33%), followed by NY (27%) and then North Central (19%). The lowest proportion are in New England (6%), followed by Mid Atlantic (10%). The South East has the highest proportion in state agencies (59%), and California the lowest (20%). California has the highest proportion in municipal agencies (53%), and Mid Atlantic the lowest (10%). CBO and Hospital OPD hours vary by region: for CBO, South East reports the highest and NY the lowest; for Hospital OPD, NY reports the highest and the West the lowest. Inpatient hours do not vary significantly by region, but South East reports the highest and New England the lowest.

Job type varies by region. Staff psychiatrists are distributed evenly, but program medical directors are concentrated in NY. Agency medical directors are most common in North Central and South East and least

common in New England and California. Breadth of supervision varies by region. South East has the most medical directors who supervise medical staff only and New England the least. Mid Atlantic, North Central and South East have the most supervisors of medical and clinical staff, and California and the West the least. NY has far more supervisors of all staff than any of the other regions.

There are no significant regional differences regarding changing populations, but NY records the greatest change in contact with people with AIDS; interestingly California records the lowest. NY also records the greatest change in contact with people coming out of jails and prisons, and Mid Atlantic records the lowest. California records the greatest change in contact with both substance abusers and the homeless, and New England the lowest.

DISCUSSION

The typical AACP member is a Caucasian male, aged 52, who lives in NY or California, is an agency medical director in a community-based nonprofit agency working half-time and earning a salary of \$125,000 – \$150,000 based upon a full-time position.

The fact that AACP membership, at least as reflected in this survey data, is so heavily dominated by Caucasian males should be a concern for the organization. On the other hand it is not much of a surprise that NY and California have by far the most number of members. It is also not a surprise that agency medical directors constitute the largest category by job type, but it is notable that 1/4 of respondents report that they are program medical directors and 1/3 staff psychiatrists.

Respondents work in nonprofit agencies more often than any other type, with state facilities second. Very few work in for-profit or federal agencies. As befit an organization of community psychiatrists, respondents work far more hours in CBOs, compared to hospital inpatient settings or hospital outpatient programs. Agency medical directors are significantly more likely than program medical directors to work in CBOs, while program medical directors are significantly more likely than agency medical directors to work in hospital inpatient or outpatient settings. The median salary is in the \$125,000–\$150,000 range, and agency medical directors make significantly more than program medical directors, who in turn make significantly more than staff psychiatrists.

Women are significantly younger than men and make a significantly lower salary. A regression analysis reveals that the age and salary

effects are relatively independent of each other. Women are slightly more likely to fill program medical director positions, and less likely to fill agency medical director positions, but the difference is not significant. Women report significantly less overall change and slightly lower impact.

Overall change and overall impact is not associated with region. It is hard to find any over-riding regional differences, but differences that appeared are of interest to people practicing in these varying regions. Of particular interest is the fact that economic changes effected people practicing in the Mid Atlantic region far more than those in the North Central region. Managed care changes were highest in the Mid Atlantic region and lowest in NY. Mergers occur most frequently in New England and least frequently in NY. The North Central region reports significantly higher salaries compared to the West.

Job type varies by region. Staff psychiatrists are distributed evenly, but program medical directors are concentrated in NY. Agency medical directors are most common in North Central and South East and least common in New England and California.

CONCLUSION

As reported in the companion article, "Public Psychiatrists' Perceptions of Changes over the Past 5 years", economic factors have had the most negative impact on public psychiatrists over the past 5 years, while most of the other domains studied had positive impacts. This paper reveals that the impact of economic factors has been experienced unevenly throughout the country, as are two highly publicized aspects of economic factors, managed care and mergers/acquisitions.

When this study was originally conceived in the late 1990s, managed care seemed to be the driving force resulting in major changes in private sector psychiatry, and it appeared inevitable that it would have similarly major impact on public sector psychiatry. This survey reveals that managed care has indeed had a major, and as expected, negative impact on public sector psychiatry. But it is by no means the major factor driving changes in the field. Respondents to this survey have experienced higher changes in psychopharmacology, budget and staffing, and productivity demands. Changes in psychopharmacology and budget and staffing also have had higher impacts on public psychiatrists, albeit the former positively and the latter negatively. Thus, while managed care has certainly had a negative impact on public

psychiatrists over the past 5 years, economic factors (especially budget and staffing changes) have had the most negative impact.

However, the negative impact of economic factors is not the whole story. Public psychiatrists have experienced positive changes in the other 5 domains studied (scientific and clinical activities, organizational changes, information systems, advocacy and changing populations). For the most part, these positive changes were experienced without major regional differences. These positive findings are somewhat surprising, because the generally negative tenor of public comments over the past 5 years would suggest otherwise. These findings suggest that when psychiatrists are asked to reflect calmly on the changes they have experienced in the past 5 years, the positive changes become more apparent.

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