

## Essential and Nonessential Roles for Psychiatrists in Community Mental Health Centers

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The role of the psychiatrist in community mental health centers (CMHCs) has been discussed, debated, and argued about for more than 20 years (1). Although there has yet to be agreement about what psychiatrists' roles should be, their actual involvement in CMHCs has changed markedly over that time. Not only has the percentage of psychiatrists on CMHC staffs decreased, but fewer psychiatrists hold CMHC leadership positions (2-4). Indeed, there is concern that psychiatrists in CMHCs are being increasingly relegated to signing forms and writing prescriptions and that control over treatment decisions is being assumed by nonmedical professionals who lack the training to fully appreciate the biopsychosocial com-

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plexities of seriously mentally ill patients (5).

While most psychiatrists view their changing role in CMHCs with alarm (6,7), many nonmedical mental health professionals seem relieved to be free of the domination and perceived limitations of the medical model (8). Whether these changes are considered good or bad, it is clear that a problem exists in the relationship between psychiatry as a profession and CMHCs. In view of this ongoing debate, we offer our thoughts about what we consider to be essential roles and nonessential but highly desirable roles for psychiatrists in the CMHC setting.

### Essential roles

The physician in a CMHC fills two roles that cannot be filled by other mental health professionals. The first is that of medical expert, the second that of legal or medical authority.

*Medical expert.* The main role filled by a psychiatrist is that of medical expert. This role includes such activities as evaluating for medical illnesses that might present as psychiatric; helping evaluate, triage, and treat purely medical illnesses; assessing and monitoring patients so that psychotropic medications can be appropriately prescribed; and acting as translator between nonmedical staff and other community physicians.

*Legal or medical authority.* The second necessary role—that of legal or medical authority—is based on the M.D. degree rather than on any necessary expertise. Third-party payers, courts, and even employers often require a letter from “the doctor” rather than from staff who know the patient best. Negotiating with outside agencies such as welfare

or social services, the legal system, or other parts of the medical system—and even with the patient and his or her family—frequently requires the clout of the M.D. degree.

The necessary roles of the psychiatrist in the CMHC are important but not particularly controversial. The question is what other jobs the psychiatrist might have in addition to the two mentioned above. That depends on one's point of view. One might argue that certain roles should be the psychiatrist's, based on history, administrative decree, or state law, but today these arguments have less and less sway. If we as psychiatrists wish to play more than a minimum role and ensure that CMHC patients benefit from our expertise as well as our pharmacology, then we will have to argue additional roles and tasks for ourselves, based on our individual competence.

### Nonessential but desirable roles

In our view, there are at least four nonessential roles that are desirable for the psychiatrist: assessor, generalist, teacher, and scholar. We believe that psychiatrists who are both interested in and appropriately trained for these roles are more likely than other mental health professionals to have the expertise and competence to fill them. While the psychiatrist is not the only one who can fill them, these roles should be assigned, formally or informally, to the most expert member of the team. If psychiatry is interested in having a broader rather than narrower role within CMHCs, it becomes the responsibility of training institutions and psychiatrists themselves to ensure that they have the required degree of competence as assessors, generalists, teachers, and scholars (9,10).

*Assessor.* First, the psychiatrist can play an important role in the initial assessment and treatment planning processes, one that goes beyond the essential roles of just screening for medical illness and assessing for medication needs. The organized information gathering that occurs in initial assessments is emphasized far more in physician training than in

training other mental health professionals. An organized initial assessment is particularly important for a severely ill patient.

Similarly, active involvement in the treatment planning process affords the psychiatrist the chance to be involved in all aspects of the patient's treatment. While there is no particular advantage in requiring the physician to be in charge of the intake process, a psychiatrist who has broad-based expertise and interest can help suggest or consider different treatment approaches and help to integrate these approaches into a comprehensive treatment plan.

**Generalist.** Second, the psychiatrist is in an excellent position to be the team generalist. It is important for someone to know something about all aspects of mental health treatment in order to be aware of and to call in particular expert services when needed, thus making use of approaches that are somewhat out of context with how the patient is being treated. While many psychiatrists are too narrowly trained to fulfill this role, the potential exists in some psychiatric training programs for psychiatrists to develop true expertise as generalists.

Psychiatrists serious about being generalists must develop expertise in many areas not included in traditional training. Those preparing to work with the difficult patient should be trained in how to combine behavioral interventions, family therapy, psychosocial rehabilitation, intrapsychic dynamic considerations, and psychopharmacology into one integrated package.

Psychosocial rehabilitation, family therapy, and psychoeducational models for working with families are particularly important areas in which physicians in CMHCs should be trained. They should also be well versed in the area of crisis intervention, both as treaters and as consultants. Behavior therapy, behavioral contracts, and paradoxical therapy can also be enormously useful as an adjunctive approach for particular patients. The psychiatrist's expertise in psychotherapy, particularly in the transference and countertransference processes, can help the team or

particular staff members clarify why they are feeling so angry toward a particular patient.

Basic knowledge of mental health law and economics is also critical. Certainly social psychology and the psychology of groups, along with some less academic topics such as local politics and the impact of changes in health insurance, are all areas in which a knowledgeable psychiatrist can contribute to the rest of the mental health team. With this kind of broad-based, integrative training, psychiatrists can be tremendously helpful in developing treatment plans that use multiple approaches and therapies.

**Teacher.** A third nonessential but desirable role for the CMHC psychiatrist is that of teacher and clinical consultant—about mental illness in general and psychotropic medications in particular. The psychiatrist in this role might make formal presentations to the staff, give lectures in the community, or engage in frequent case consultation on a case-by-case basis.

Teaching other mental health professionals by involving them in decisions about why a particular medication was chosen, why a particular dose was chosen, or why changes were made can be another very important aspect of this role. Indeed, the more the nonmedical staff know about what information is needed and how the decisions are made, the more likely they are to be useful in bringing relevant and appropriately organized information to the psychiatrist's attention and to engage in a cooperative relationship, thus ensuring that the most effective clinical decisions are made.

Psychiatrists can work to facilitate the consultative nature of their relationship with the rest of the staff and, as consultants, can be useful in many ways beyond those that are essentially medical. For instance, a request for medication consultation may be precipitated by a nonmedical staff member's sense that the case is not going well; at times a request for general consultation and review is based on more explicit concerns.

The psychiatrist can also help the team put their day-to-day experience

in a larger context. Front-line workers faced with finding the same chronic mentally ill patient yet another apartment or dealing with the fourth round of an oft-occurring crisis can be helped greatly by the psychiatrist who can step back and provide some helpful perspective, perhaps by noting the decrease in frequency of crises or in psychiatric hospitalizations over the last two years. Such perspective is hard for line staff to maintain on a day-to-day basis.

Although the role of teaching or community liaison to social service agencies, courts, welfare agencies, or other possible resources is not uniquely open to physicians, it is another easy one for them to fill. Outside agencies generally respond well to physicians, and the interest of the physician frequently paves the way for a service liaison or a cooperative arrangement that might require more negotiating by another mental health professional.

**Scholar.** The fourth role for the psychiatrist is that of a scholar. We do not mean just someone who happens to be connected with a university, but rather someone who can help the rest of the mental health team stay current with the relevant literature as well as providing a conceptual overview of the day-to-day work accomplished. The psychiatrist who is well trained and who continues to read can bring in carefully selected papers that are particularly germane to problems the staff have faced.

## Conclusions

Although many of the roles that can be filled by a psychiatrist can also be filled by other professionals, some roles, particularly those with medical and legal ramifications, make the psychiatrist a needed part of every community mental health center staff. There are other roles—assessor, generalist, teacher, and scholar—for which a psychiatrist, if interested and appropriately trained, may have an advantage in developing the required expertise. But because these roles can be assumed by others, a psychiatrist who is not appropriately prepared cannot demand that certain roles "should" be left to the psychiatrist.

Psychiatrists can do their part to maintain their usefulness and importance within the CMHC by developing a broad range of skills in addition to their basic medical expertise. CMHC administrators, in turn, need to make sure that the psychiatrist's role is not limited to prescribing medication. We believe that if psychiatrists are forced to relinquish too many of their roles, CMHCs will not be an attractive place for them to work, and recruitment of psychiatrists to CMHCs will continue to be an increasing problem. Given a cooperative approach, psychiatrists can end up feeling professionally validated, while nonmedical mental health professionals can continue to fill important roles that were at one time reserved for physicians.

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## Unusual Case Reports

# Melancholia and Orders to Restrict Resuscitation

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To protect patients' rights and to assure the quality of medical judgments, standards governing the issuance of orders to restrict resuscitation have been developed (1). This report describes circumstances in which a group of medical professionals repeatedly approved orders to withhold resuscitation in conflict with such standards. It suggests the need to incorporate additional precautionary measures into standards for restricting resuscitation of patients with a diagnosis of functional psychiatric illness.

#### Case report

A 69-year-old Caucasian man was admitted to a general hospital psychiatric ward after his wife complained about his poor appetite, medication refusal, and feelings of hopelessness. He appeared pained, cachectic, intensely sad, and hypoactive; showed generalized weakness; and failed to follow simple commands. His sparse speech was dom-

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inated by guilt and hopelessness. He admitted no suicidal thoughts, delusions, or hallucinations. His vital signs were within normal range, and he had no history of substance abuse.

Ten years before admission the patient had suffered from his first bout of depression and recovered without treatment. He had been suicidal and severely depressed three years before the current hospitalization, but treatment with a variety of antidepressants proved unsuccessful. Each of two courses of electroconvulsive therapy (ECT) led to a full but temporary remission.

Two years before the patient's admission, he and his wife, a retired nurse, had signed uniform standard living wills directing that if (and only if) he or she were in a terminal state with death imminent from an incurable condition, life-sustaining procedures that would only prolong dying were to be withheld. The living will was to apply even if the patient became incapable of giving directions.

Soon after admission, the patient fell into a depressive stupor, followed by pneumonia with dehydration. After resolution of the pneumonia, a no-resuscitation order was written; the accompanying note simply claimed the patient's living will as justification. The patient received regular nasogastric feedings; his weight stabilized, but he did not walk.

Four months after admission the county court judged the patient legally incompetent and appointed his wife as his guardian. The patient revealed suicidal thoughts. With consent from his wife, he received ten bilateral brief-pulse ECTs, which resulted in full remission of his de-

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## Letters

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*Letters from readers are welcomed. They will be published at the discretion of the editor as space permits and will be subject to editing. They should be a maximum of 500 words with no more than five references and should be submitted in duplicate, typed double-spaced. Writers' affiliations will be published.*

### Psychiatrists' Roles in CMHCs

*To the Editor:* While I have the utmost respect for my community psychiatry colleagues Drs. Diamond, Stein, and Susser, and while I appreciate their taking another cut at the complex issue of the community psychiatrist's roles in their February paper (1), I worry that their delineation of essential and nonessential roles will perpetuate the all-too-prevalent practice of marginalizing psychiatrists in many community mental health settings.

It is important to note that Drs. Diamond, Stein, and Susser practice in community mental health settings

that have strong academic ties. Typically, psychiatrists who practice in CMHCs affiliated with an academic center or a hospital or both experience less role strain than their counterparts in freestanding CMHCs. I suspect that in academic- or hospital-affiliated CMHCs there is implicit, if not explicit, delineation of the psychiatrist's leadership role. It is the erosion of the psychiatrist's clinical leadership role, particularly in freestanding CMHCs, that has prompted both the formation of the American Association of Community Psychiatrists (AACP) and the development of the Guidelines for Psychiatric Practice in CMHCs by AACP and the American Psychiatric Association (APA) (2).

Drs. Diamond, Stein, and Susser identify only two roles as essential for psychiatrists in CMHCs—those of medical expert and of legal and medical authority. However, in an effort to reverse the inappropriate marginalizing of psychiatrists and their utilization only in these two roles—for medication checks or for signing reimbursement and other forms—the guidelines spell out comprehensively what the clinical leadership role of the psychiatric medical director entails.

I believe that the guidelines essentially advocate that the CMHC psychiatrist, particularly the medical director, fulfill his or her overall clinical leadership role by being the assessor, the generalist, and the teacher—roles the authors identified as nonessential but desirable—as well as the medical expert and the legal or medical authority. It seems to me that these roles collectively constitute the psychiatrist's clinical leadership role.

I fear that to regard the roles of assessor, generalist, and teacher as nonessential for CMHC psychiatrists and to fail to advocate for the broad clinical leadership role delineated in the AACP and APA guidelines will simply perpetuate problems with quality of care for patients as well as the problems in recruitment and retention of psychiatrists that currently exist in many CMHCs, especially those that are freestanding.

Early in the community mental health movement, psychiatry was

clearly in charge, both administratively and clinically. With the waning of psychiatrists in executive director positions, there has been a concomitant slippage in the number of psychiatrists in clinical leadership positions. While a psychiatrist need not be the executive director of a CMHC, it is now the position of AACP and APA that all mental health centers should have medical directors. The clinical leadership functions of these medical directors are delineated comprehensively in the guidelines.

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*To the Editor:* We were surprised that the one role we consider to be essential, that of a scientist, was not discussed by Drs. Diamond, Stein, and Susser (1) in their commentary on roles of psychiatrists in community mental health centers. Psychiatrists who work in CMHCs are in the fortunate position of having a comprehensive scientific background that in many cases also includes both practical and theoretical knowledge about research skills and quality assurance programs. Patients seen in CMHCs are a tremendous potential source of research interest and data. Basic scientific methods applied to quality assurance programs within such centers can greatly improve clinical skills, patient treatment programs, and staff morale.

From our experience working in a CMHC in an isolated part of Australia, where the nearest psychiatric admission center is 500 kilometers away, we have found that the psychiatrist has been able to greatly improve the clinical management of pa-

tients in his role as researcher and quality assurance expert. We have used our research studies to successfully argue for greater resources and to improve the data collection systems that we use routinely. Our research is now beginning to lead to publication.

Members of the community mental health team, including ourselves, are presenting our findings at conferences and workshops in Australia. There is no doubt that this type of activity, and the ensuing success, has very greatly lifted the morale of the mental health team, which, of course, leads to improvement in the quality of their work with patients.

We do not know if research is widely conducted in community mental health centers in the United States, but we feel that any psychiatrist working in a CMHC should certainly consider the possibility.

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*In Reply:* We appreciate the thoughtful responses to our article by Dr. Clark and by Dr. Yellowlees and Mr. Hemming. We agree with Dr. Clark that it is important for psychiatrists working in CMHCs to have roles that extend well beyond the "essential" roles of narrowly defined medical expertise and medical authority. As members of the American Association of Community Psychiatrists, we agree with Dr. Clark that CMHCs should have psychiatrists as medical directors with broad clinical leadership roles.

Our own roles in our respective CMHCs and community outreach programs have included a more holistic leadership role, and the psychiatric residents who train in our programs would not be willing to work in a CMHC that limits their role to prescribing medication and signing forms. Well-trained psychiatrists have expertise that includes assessor, generalist, and teacher, and

CMHCs that want to attract and retain the best of our profession will have to ensure that all the expertise of their psychiatrists will be respected and used.

Where we disagree with Dr. Clark is in his assumption that one can legislate this broader leadership role. Saying that the psychiatrist should be the assessor or generalist will not make it so if other members of the interdisciplinary team are more competent to fulfill these roles. If the psychiatrist has little to add to what can be done by nonmedical professionals, a required review by the psychiatrist inevitably becomes an empty, pro forma exercise. If the psychiatrist has much to add, the other team members will seek out his or her consultation because they find it useful, whether the review is formally required or not.

Of course, structural barriers in some CMHCs interfere with this process. An expectation that psychiatrists be scheduled for a "med check" every 15 minutes, discouraging contact with others, or a strong adversarial relationship between professional groups will all make consultation difficult and may make it impossible to develop a leadership position. Psychiatrists with broad training, including training in such areas as how to be an effective consultant, can often overcome these initial barriers and carve out a comprehensive role for themselves.

In summary, we agree with Dr. Clark that psychiatrists need to have more central rather than marginalized roles in CMHCs. However, we believe that appropriate training and demonstrated competence are more likely to lead to this end than policy statements that do not address the underlying realities of the relationship between the psychiatrist and the CMHC.

The comments by Dr. Yellowlees and Mr. Hemming clearly address an oversight on our part. Because CMHCs and community outreach programs give care over long periods of time in naturalistic settings, they provide unique and exciting opportunities to investigate a wide variety of research questions that cannot be studied elsewhere. These include

longitudinal studies of the course of illness and evaluation of clinical programs, patients' quality of life, and patterns of staff interaction. We also agree that such endeavors, when undertaken by a multidisciplinary team, enhance the morale and quality of work done by center staff.

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## Obsessions and Compulsions

*To the Editor:* The progress report by Drs. Foa and Kozak (1) on the DSM-IV diagnostic criteria for obsessive-compulsive disorders in the July issue is marred by misunderstandings. It is simply false to claim, as they do, that "the traditional view" maintains that "obsessions are mental" and "compulsions are behavioral," or that "obsessions and compulsions can be independent of each other," or that "individuals can always recognize that their obsessions and compulsions are senseless." Furthermore, the DSM-III-R approach to obsessions and compulsions is easy to criticize, reflecting as it does many decades of neglect and disinterest in phenomenology. However, the authors take an admittedly bad situation and make it worse.

Traditionally, the term obsession refers to besiegement. In the Middle Ages, for example, agents of the Inquisition attempted to distinguish between individuals possessed by demons and those merely obsessed by them. With respect to obsession (2), the devils and demons vexed, hovered about, and harassed the victim, but they did not possess him, which means that they did not enter into his body and soul and totally overcome him. Possession was somehow resisted (2). In psychiatry, the distinction between obsession and possession is replaced with a distinction between obsession and delusion. The one must be understood in contradistinction to the other.

The term compulsion has equally old usage and refers to the condition of being compelled, constrained, obliged, or coerced. By this usage, actions and behaviors can be compelled, but so can thoughts, moods,