

# A Three-Decade Perspective on Community and Public Psychiatry Training in Oregon

Rupert Goetz, M.D.

David L. Cutler, M.D.

David Pollack, M.D.

Neil Falk, M.D.

Elizabeth Birecree, M.D.

Bentson McFarland, M.D., Ph.D.

George Keepers, M.D.

Dale Walker, M.D.

**The public psychiatry training program at Oregon Health Sciences University, established in 1973, educates psychiatric residents to work in community mental health centers and state hospitals. The authors present a brief history of this program, which spans three decades, and describe recent developments in its operation, with special attention to financing, administrative structure, and educational elements. Several program graduates have chosen careers in public-sector work. The program is founded on the principle that just as dollars should follow patients in health care systems, so should residents in training follow patients. Administrative and fiscal arrangements must be flexible to support this mobility. (*Psychiatric Services* 49:1208–1211, 1998)**

**T**he twin problems of recruiting and retaining psychiatrists in public-sector work has concerned training programs for several decades (1–3). Universities and state mental health authorities have developed administrative relationships to address these issues (4), forming public-academic liaisons as a vehicle for public-sector psychiatric education (5–11).

The public psychiatry training program at Oregon Health Sciences Uni-

versity (12–15) has survived and has continued to mature for more than 25 years despite the changing economic and political climate. This paper discusses the economic, administrative, and teaching principles that guide the program's model for exposing psychiatric residents to community practice. It also describes the program's evolution during a period when health care reform has increasingly influenced the training of future psychiatrists.

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*Dr. Goetz is adjunct assistant professor and associate director of the public psychiatry training program in the department of psychiatry at Oregon Health Sciences University. He is also medical director of the Oregon Office of Mental Health Services, 2575 Bittern Street, N.E., Salem, Oregon 97310 (e-mail, goetzr@mail.mhd.hr.state.or.us). Dr. Cutler is professor and director of the public psychiatry training program, Dr. Pollack is adjunct associate professor and associate director of the public psychiatry training program, Dr. Falk is assistant professor, Dr. Birecree is assistant professor, Dr. McFarland is professor, Dr. Keepers is associate professor and residency training director, and Dr. Walker is professor and chair in the department of psychiatry at Oregon Health Sciences University. Dr. McFarland is also professor in the department of public health and preventive medicine at the university.*

## **Beginnings of the program**

Oregon Health Sciences University's public psychiatry training program began in the 1970s, a decade when ensuring adequate psychiatrist staffing in public settings was equally as difficult as it is now. In the early 1970s, before the program was established, 50 percent of the dollars for community mental health programs in Oregon were provided by the state, and 50 percent were matched by the counties. The state operated two psychiatric residency programs—one at Oregon State Hospital and the other at Oregon Health Sciences University.

Dr. J. Don Bray trained at Oregon State Hospital in the 1960s and went on to lead the state's mental health division in the 1970s. In 1971 he and his assistant, Dr. Del Kole, a graduate of the residency program at Oregon Health Sciences University, were able to interest state legislators in developing a collaboration between the psychiatric residency programs at the two facilities to create a training program in community psychiatry. The purpose of this program, later called the public psychiatry training program, was to train psychiatrists to work in rural areas and state hospitals.

Two state senators and Dr. George Saslow of the School of Medicine at Oregon Health Sciences University worked with Drs. Bray and Kole to

secure a grant from the National Institute of Mental Health to develop the program. Although the grant was approved, funding was canceled before work on program development could begin. Through the effort of Senator Newbry, chair of the state's legislative emergency board, state general funds were appropriated to pay for the project.

The creation of an advisory board and state funding were key administrative and fiscal factors in establishing the initial state-university linkage. The advisory board established policies and priorities for the training program and periodically evaluated the program and the performance of its director, but remained uninvolved in day-by-day operations. The board included some of the program's original planners, as well as representatives of the medical school, the medical school's department of psychiatry, the state mental health division, the state hospitals, and the directors of community mental health programs.

State funding provided the university with stipends and a small travel budget to allow residents to travel to any of the state's community mental health centers or state hospitals. The residents being trained at Oregon State Hospital were given similar opportunities.

As part of the joint educational program, residents from Oregon State Hospital traveled to the medical school for seminars and supervision. Dr. James Shore, the first director of the training program, met with county mental health program directors throughout the state and set in place the infrastructure for residents' community rotations. An interdisciplinary seminar was developed collaboratively with faculty and students of the School of Nursing at Oregon Health Sciences University and the School of Social Work at Portland State University. Later, in 1977, when the federal rural mental health grant was funded, additional faculty members were hired, one of whom is the current director of the public psychiatry training program. An additional linkage was established in 1978, when the state mental health division contracted with program faculty for consultation. This contractual relationship remains in effect.

### **Adaptations in the 1980s**

In 1980 the state assumed responsibility for administration of 100 percent of the dollars for mental health care of persons with chronic mental illness and persons at risk for hospitalization. Funding was available only for services for these first-priority clients. The training program adjusted its curriculum so that its graduates were prepared for this new system (12).

In the mid-1980s, even though the state had plans for continued deinstitutionalization, a shortage of physicians was still apparent at the state hospitals. Oregon tended to offer lower salaries than its neighboring states, and psychiatrists who had trained in Oregon were leaving to find better-paying jobs elsewhere. The residency program at Oregon State Hospital was about to lose its accreditation because it was unable to provide the broad clinical experience required. If the training program was to continue operation, more money was needed to hire additional staff and support additional residents.

The training program arranged a consultation with representatives of the University of Maryland's state-university collaboration project, which was known for its ability to integrate state hospital and university programs. After that site visit, the state mental health division concluded that it could not afford to upgrade the psychiatric residency program at Oregon State Hospital. Instead the division reallocated resources from the training program at the state hospital by transferring stipends for five residents to the university, and using four stipends to fund two staff psychiatrist positions at the state hospital. The position of training director was transferred to the Oregon mental health division. The training director also held the appointment of associate director of the public psychiatry training program and was to devote 20 percent of his time to program activities. In addition, a special training unit was developed at Dammasch State Hospital.

By 1990 the public psychiatry training program was staffed by a director, an associate director, and two assistant directors. The collaboration included linkages between Dammasch State

Hospital, community mental health programs, the state mental health division, and the Western Mental Health Services Research Institute. The advisory board continued to meet each year to manage the interface among the various participants.

### **New ideas in the 1990s**

During the 1990s, mental health care delivery systems have changed even more rapidly than before. In Oregon the Medicaid system that limited state funding to care of persons with chronic mental illness has been replaced with a capitated Medicaid system responsible for providing care for all eligible persons at or below the poverty level. The state contracts with both county mental health authorities and managed mental health care organizations to deliver these services. The spectrum of services to be covered is now governed by a prioritized list under the Oregon Health Plan (16).

Deinstitutionalization has continued as well, and the 300-bed Dammasch State Hospital, which the public psychiatry training program worked with most closely, is now closed. The part of the program previously affiliated with the hospital moved to a new public-sector entity called the extended care management unit, situated in the mental health division. The unit is responsible for making appropriate placements for hospital patients and for monitoring their condition, whether they are in the hospital or residing in a group home or an apartment or other form of independent housing.

The stipends for state hospital residents were moved to the new unit so residents could follow patients both in and out of the hospital and obtain a better longitudinal perspective on patient care. Because the stipends are no longer hospital based, residents can be relocated to other sites if the hospital becomes a less feasible base from which to follow long-term patients. Residents are supervised by faculty formerly based in the hospital but who now are also part of the staff of the extended care unit.

In 1994 Oregon obtained a research grant to compare case management services provided by consumers with those provided by non-consumer mental health profession-

als. In this project, a team of persons who have suffered at some time from a major mental illness provided case management services to 40 persons with severe mental illness, and a team of nonconsumers with a background in mental health provided services to a control group with similar clinical profiles. The psychiatrist who was the clinical director for this project was hired as an assistant director of the public psychiatry training program.

At the state mental health division, the position of director of psychiatric education evolved into that of medical director of the Office of Mental Health Services. This person currently serves as associate director of the public psychiatry training program, forging additional ties between the program and the state division.

Combined funding sources allowed the hiring of an additional assistant professor who serves a variety of functions in community programs, including county-level services that arrange discharge planning and trial visits to the community for long-term hospital patients. This faculty member also works with a community mental health center in downtown Portland that provides ongoing care to adults in the city's only shelter for homeless mentally ill persons, the shelter's associated drop-in center, and single-room-occupancy housing units. In addition, he is the medical director of a street outreach-crisis intervention team in Portland, Project Respond, which received the Gold Achievement Award from the American Psychiatric Association in 1997 (17).

By working at multiple levels of the community system, this faculty member has produced an additional strong link between inpatient providers, outpatient providers, administrative services, and the public psychiatry training program. His ties with a range of innovative community programs have given psychiatric residents the opportunity for involvement in unconventional and creative approaches to care delivery for traditionally difficult-to-treat populations.

### **Current program**

Most of the program's formal training consists of seminars and rotations in residents' second and third postgrad-

uate years. A seminar is held for the second-year residents, all of whom have an extended care management rotation at a new downtown acute state hospital setting not far from Oregon Health Sciences University.

Third-year residents select from among various programs in Oregon county agencies, private nonprofit agencies, and some managed care organizations and networks. Upon choosing a site, they spend four to six weeks visiting the agency's components and allied community sites that serve the agency's clients. Then they negotiate a "contract" with the agency that describes their objectives and activities for the remainder of the six-month, two-day-a-week rotation. The residents receive money from the training program for travel expenses, and all stipends are paid by the state. This arrangement enables residents to design their own rotation according to their particular clinical, research, and administrative interests. Residents are allowed to leave a program site if they are dissatisfied with it, and they are helped to find another placement as they might if they had a job they did not like. They receive individual supervision on site from the program's staff and from university faculty.

A two-hour interdisciplinary seminar that has been a feature of the program since its inception is updated biannually. The seminar broadly covers the field of community mental health, but over the years the emphasis has changed from rural community psychiatry and mental health consultation to the problems of target populations such as persons with serious and persistent mental illness or dual diagnoses, and to issues of civil commitment, case management, cross-cultural topics, and managed mental health care in the Oregon Health Plan.

### **Challenges on the horizon**

The mental health system in Oregon is currently being integrated into the managed mental health care arrangements already in place for Oregon Health Plan. The plan includes all persons up to the poverty level, not just persons with severe mental illness. The mental health division has awarded contracts to community mental

health programs, county mental health authorities, and private organizations to provide capitated services.

Funding of trainees' placements under the new managed care format presents both challenges and opportunities. In a related training program, social work students in community placements largely depended on state funding to the agencies where they were placed. In that program an initial reaction to capitated funding was to discontinue placements because billing for them was unclear. However, the mental health division's contracts include provisions for the use of trainees under the concept of flexible service approaches where adequate supervision is provided, thereby supporting social work student placement. Due to its protected funding, the public psychiatry training program avoided this problem.

Clearly, understanding the implications of managed care has become important for anyone wishing to work in public mental health. The curriculum offered in the public psychiatry seminar has been expanded to include in-depth coverage of these issues. Residents are able to participate in efforts to implement managed care through the Oregon Health Plan by participating in rotations in the counties where this approach has been introduced.

### **Program achievements**

The public psychiatry training program has had a mission to distribute its graduates throughout the state of Oregon to community mental health centers, state hospitals, and rural areas primarily to serve public patients. Of the 218 residents who finished their training between 1974 and 1997, 48 took full-time jobs in community mental health centers after graduation, and 45 took part-time jobs in those settings. Another 33 took jobs in state hospitals. Forty-six graduates, or 21 percent, began their practice in rural areas without any state payback obligation, practicing in a mixture of local community mental health center and private activities. Most are still in the same locations in which they started. Overall, 160 graduates, or 73 percent, took positions in some form of public-sector psychiatry. Through ongoing contacts with

Oregon's county mental health programs and state hospitals and with the Oregon Psychiatric Association, and by means of the annual meeting of public psychiatrists sponsored by the mental health division, we have kept track of the more than 60 percent who continue to work in public settings and we estimate that at least 75 percent of that group are still in Oregon. These results have occurred during a time when community and state hospital psychiatry has declined markedly as a career choice for most psychiatrists nationwide (18).

Mental health programs have consistently sought fourth-year residents from the public psychiatry training program for rotations at their facilities. These arrangements have involved small contracts with an hourly rate. Funds are used to provide travel and other benefits for the residents. These rotations have led to permanent job offers. Residents have also worked to improve relationships between mental health agencies and a variety of other entities, especially primary care clinics, corrections systems, residential care facilities, and consumer and family organizations (19).

## Conclusions

The data on program graduates' career choices suggest that the public psychiatry training program influenced their selection of practice sites and of the patient populations they treat. The department of psychiatry of Oregon Health Sciences University has developed a national reputation for excellence in residency training and has been able to attract high-quality graduates despite the decline in interest in psychiatry nationwide. In addition, faculty associated with the public psychiatry training program have been able to develop successful academic and research careers despite being involved in what has been a demeaned, underpaid, and stigmatized corner of psychiatry.

What have we learned? An obvious lesson is that to survive change, a program must adapt. But what parts should change, and what parts should remain stable? Our structure has allowed us to avoid the multiple pitfalls described by Faulkner in his 1994 commentary (20). Over time it is

clear that the program has been a buffer for managing change. Because the program influences both the training process and mental health planning at the state level, it is uniquely positioned to bring together the disparate forces that may otherwise overlook training needs in public psychiatry. At the same time, the program offers a safe environment in which the residents can sample from the broad menu of opportunities available in the public sector.

No matter where public patients are to be found, training must prepare residents for that environment. Thus the program administratively brings together the stakeholders, controls the funding, and allows residents to go where they are needed. Much has been said about how dollars must follow patients. For a public psychiatry training program to be successful, residents must follow patients as well. A program such as the public psychiatry training program can be an invaluable tool to assure that the administrative structures for accomplishing this goal are in place and that training dollars and administrative structures follow the residents. Attention to these principles can help support trainees' effective exposure to and recruitment into public psychiatric practice and can support creation of a training program that survives over time by adjusting successfully to changes in public and fiscal policy. ♦

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