Mental Health and Primary Medical Care

Formulated by the Committee on Preventive Psychiatry
Group for the Advancement of Psychiatry

MENTAL HEALTH MATERIALS CENTER
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TABLE OF CONTENTS

STATEMENT OF PURPOSE ........................................ 699
COMMITTEE ACKNOWLEDGMENTS ................................ 705

1 INTRODUCTION AND BACKGROUND .......................... 707

2 TRAINING PSYCHIATRISTS TO BE EDUCATORS IN PRIMARY CARE ............................................. 712
   Rationale
   The Scope of Mental Health Problems
   Medical Education and Issues of Hierarchical and
   Stereotypical Attitudes in the Profession
   The Psychiatric Teacher-Consultant
   Teaching About Referral
   Undergraduate Medical Teaching
   Residency Training in Primary Care
   Continuing Education and Staff Development

3 THE PSYCHIATRIST AS COLLABORATOR IN PRIMARY CARE PRACTICE ............................................. 734
   Private Primary Care Practice in Collaboration with
   Mental Health Personnel
   Primary Care Centers in General Hospitals
   Prepaid Health Care: Foundations and Health
   Maintenance Organizations
   Neighborhood Health Centers
   Evaluation and Accountability

4 CONCLUSION .................................................. 754
   Teaching and Training
   Integrated Services

APPENDIX ...................................................... 758
REFERENCES .................................................. 765

BIBLIOGRAPHY FOR FURTHER READING ..................... 774
STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the fields of psychiatry, mental health, and human relations
2. To reevaluate old concepts and to develop and test new ones
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

Mental Health and Primary Medical Care was formulated by the Committee on Preventive Psychiatry which acknowledges on page 705 the participation of others in the preparation of this report. The members of this committee are listed below. The following pages list the members of the other GAP committees as well as additional membership categories and current and past officers of GAP.

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Finally, the editorial assistance of Louise H. Fleck and Catherine Molloy has been invaluable for the committee.

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INTRODUCTION AND BACKGROUND

The rapid changes in health care that are occurring in the United States make it imperative that psychiatrists review their contributions to other areas of medicine. Advances in medical sciences, concern with escalating health care costs, increasing non-professional participation in health care decisions, demands for quality control and accountability, and pressure for more personal doctor-patient relationships are changing the ways in which health care is provided.

Psychiatry's role in future health care in the United States remains uncertain, especially because practice patterns are becoming increasingly insurance-dominated. Psychiatry must strive to adapt to the emerging health care scene and should participate and lead in bringing attention to and promoting the understanding of behavior and the psychosocial aspects of medical practice.5-8

Psychiatry and other medical specialties grew enormously after World War II. Although the general practitioner was presumed to be the family medical advisor who recommended the specialist when needed, most people, at least in large cities, went directly to the specialists. The general practitioner appeared to be heading either for extinction, or for relegation to inner cities or rural districts that most specialists avoided. As laboratory medicine progressed, even the specialist became specialized. To some extent psychiatrists followed the subspecialty lead and began to limit their practices to psychoanalysis, to child and adolescent psychiatry, to geriatric psychiatry, and so on.

The specialists and sub-specialists prospered. Psychiatrists, as the only specialists primarily concerned with feelings and
emotions, were faced with a great many patients with troubled emotions. In fact there were many, far too many such patients and too few psychiatrists. So, in order to relieve the shortage, especially in the public sector, the federal government began to subsidize the training of psychiatrists as well as that of other mental health professionals. Subsidized training prospered for about two decades until it appeared that there would soon be more psychiatrists than surgeons—at least in urban areas. Psychiatric patients were on the waiting list, and concern about referrals from the rest of medicine was absent.

Meanwhile general practitioners became scarcer, and the public began to complain that the humanistic aspects of medicine were being lost; that the specialists for whom they had deserted their general practitioners were interested only in organs and diseases and not in people.

In the 1970's these complaints were heard by legislators as well as by physicians and medical educators, and legislators began to insist that medicine put its pieces back together to provide comprehensive and humanistic “primary care.” The primary physicians would then call on specialists for consultation and referral, as had been the practice before World War II.

The primary care medicine that the public seems to want includes three key elements:

1. first contact medical attention for every kind of health problem
2. continuity of care, or longitudinal responsibility for patient and/or family in health and disease
3. coordination of treatments for patients with specialized health care needs

But just as in the case of psychiatry a few decades earlier, the increased demand for primary care found the United States without enough primary care physicians. This shortage was identified in 1966 by the Citizens' Commission on Graduate Medical Education as medical education's most urgent problem. Since then, in response to the shortage, primary care training programs have been dramatically extended and student interest in this “new” field has been encouraged.

Most primary care is provided by family practitioners, internists, and pediatricians. “Family practice,” which requires postgraduate training equivalent to that of the traditional specialties, has replaced the old, depreciated “general practice” in the United States, and by the late 1970's had become the most rapidly growing branch of medicine. At the same time, many medical and pediatric residencies had been adapted to produce more primary care doctors. The interest in these programs is high among medical students; many now regard primary health careers worthwhile and exciting.

Traditionally, primary care physicians have had to help patients cope with psychiatric problems. Sixty percent of patients with psychiatric diagnoses are being followed by general health care providers, and only 20 percent by mental health agencies, while the remaining 20 percent receive no formal treatment at all. Thus, primary care physicians manage most of such patients themselves, using experience, intuition and empathy, plus whatever they have gleaned from their psychiatric teaching. However, all too often they have not perceived such teaching as relevant or applicable to their patients. They refer some patients to psychiatrists or mental health clinics, but in these instances they complain that they seldom hear much, if anything, about their patients' progress.

Until recently the aim of most psychiatric education was to provide specialists to whom other physicians would refer patients for either office or hospital care. Now, in medical schools, residencies, and continuing education settings, psychiatrists are increasing their efforts to adapt psychiatric teaching in order to encourage primary care physicians to manage the emotional aspects of their patients and to provide prompt and appropriate feedback following psychiatric referral. Meanwhile the rise of prepaid group practice and other new
health care systems has provided new opportunities for closer cooperation among primary care physicians, psychiatrists, and other health care personnel resulting in integrated mental health and general health care.\textsuperscript{15,16,17}

Although most patients will be treated by their primary physicians or in integrated services, there will always be some for whom psychiatric referral is indicated. Referral by a primary care physician is not the same, however, as referral by a specialist. Specialists usually make referrals when they do not view a patient’s condition as appropriate for their care, and are therefore not vitally concerned with the details of the psychiatrist’s diagnosis and treatment. By contrast, primary care physicians make referrals because they need the psychiatrist’s help with patients with whom they will have a continuing relationship and responsibility. Psychiatrists, therefore, need to adapt their ways of handling referrals according to the referral source.

The future roles of psychiatrists, like those of all health professionals, are being affected by another major change in health care that is taking place in this country. This change is a move from a “medical” system that emphasized illness and therapy to a “health” system that emphasizes prevention, health maintenance, optimal functioning, and child development.

The increased concern for prevention is reflected not only in physicians’ interest but even more in increased public interest in maintaining health through diet, exercise, and other preventive measures. Organizationally, the change is manifested by a shift in emphasis from traditional solo or private group practice to prepaid or subsidized health care.\textsuperscript{18,19,20}

The rapidly rising cost of health care also contributes to the interest in prevention. Successful prevention is rewarded by reduced health care costs for both prepaid and subsidized health care, whether the care is underwritten by government or by private insurers. Psychiatry needs to collaborate actively with the new health care organizations and in defining and testing preventive mental health concepts and strategies.

The emphasis on cost containment has made psychiatrists concerned about the inclusion of mental health care in the health care provisions of the future.\textsuperscript{21,22} This concern is particularly relevant when effectiveness of care is evaluated solely on the basis of objective tests of bodily health and seldom includes more humanistic criteria of functioning and feeling. Nevertheless, as insurance carriers have provided progressively greater insurance coverage for health care, they have also expanded coverage for mental health outpatient service. Mental health services are now required for “qualified” Health Maintenance Organizations, and are usually included in other prepaid plans and Neighborhood Health Centers. At the same time, quality assurance standards are challenging psychiatrists to make explicit what they do and demonstrate that they do it \textsuperscript{23,24}

If the field of primary care continues to develop as anticipated, it is likely that more people will seek mental health care from their primary care physicians. Therefore psychiatrists will be called upon more than ever before to teach students, residents, and primary care colleagues in how best to apply knowledge of mental health in the primary care setting and will be expected to work collaboratively in integrated services.\textsuperscript{25,26} Psychiatry thus has increasing teaching and service roles in primary care. The first challenge, to prepare psychiatrists for their role in primary care teaching and training, will be the subject of the next chapter. The chapter following will be concerned with integrated health/mental health practice. This document, therefore, is directed to primary care physicians as well as to psychiatrists.
TRAINING PSYCHIATRISTS TO BE EDUCATORS IN PRIMARY CARE

Rationale

Psychiatrists can help primary health care personnel to identify relevant patient complaints as mental health problems and so to provide an opportunity for early treatment. Such problems are often presented either as physical symptoms or associated with physical illness, and, as such, usually first come to the attention of a personal physician or general health service. Moreover, patients having continuing relationships with trusted physicians are likely to seek their help with personal as well as physical problems. The physician who can identify psychiatric problems at an early stage may often spare the patient a fruitless round of anxiety-provoking x-ray and laboratory examinations, as well as pointless referrals to medical or surgical specialists. \textsuperscript{1,2}

Another reason to teach psychiatry to primary care physicians is the continued absence, remoteness, or inaccessibility of mental health practitioners and agencies in many communities, in spite of a great deal of investment in money and effort in community mental health services. Even when mental health resources are plentiful and accessible, many potential users do not know about them, are not referred to them, or are ashamed to be referred there. Primary health care, on the other hand, is more readily accessible and does not have the stigma that psychiatric care per se still retains. Therefore, the more physicians know about the diagnosis and management of the emotional factors associated with or disguised as physical illness—and about when and how to make referrals—the better they can serve their patients and possibly reduce the prevalence of psychiatric disability.

On the whole, the primary physician works effectively in caring for the emotional problems of a patient when his/her knowledge of the patient's medical and psychiatric history, and of the problems of other members of the family, are considered important. But psychological problems that are presented as physical symptoms may be overlooked, and this is the area in which the psychiatrist can be most helpful in teaching family physicians how to recognize, evaluate and manage such problems. In general, a collaborative arrangement in which the psychiatrist is routinely available for consultation on run-of-the-mill problems may be as useful as any approach in bringing psychological sophistication to the primary physician, provided that the psychiatrist is attuned to the realities of primary care and family practice.

After reviewing the scope of mental health problems in primary care, we shall develop this theme first by assessing the approaches psychiatrists have used and are now using in teaching primary physicians. We will then discuss some of the modifications in these approaches which appear necessary in view of the profound changes taking place in our health care system.

The Scope of Mental Health Problems

How much psychiatric or psychophysiologic disorder is seen by a primary care physician is hard to determine. A number of epidemiological studies of this subject have been reported, but their diagnostic criteria vary considerably. According to the National Ambulatory Medical Care Survey, the diagnosis of mental disorder was made in only 4 percent of the visits to family and general physicians and in only 9 percent of the visits to internists. \textsuperscript{3} In other studies, however, the prevalence has run as high as 15 percent. \textsuperscript{4,5} Even this estimate is probably low,
since psychophysiological disorders are not always identified in primary care practice.

Perhaps a better index of the need for psychiatric input into primary care education is the number of patients for whom an understanding of psychiatric concepts would be useful for diagnosis and treatment. Rakel, a professor of Family Practice, writes:

"A patient's personality and his fears and anxieties play a significant role in all illness and its factors in all primary care... Approximately one half (of all the patients under a family physician's care) will have a significant emotional problem within any two-year period."

It is clear, therefore, that primary care physicians need to be aware of the psychosocial dimensions of health and disease, and to apply the clinical judgment necessary to formulate and implement a sound, comprehensive, practical treatment plan. Specifically they need to:

- identify the signs and symptoms of primary psychiatric disturbance or of psychosocial distress that accompanies organic illness;
- consider the individual, developmental, interpersonal and environmental factors that influence patients' and their families' coping abilities and responses to stress;
- use common psychopharmacological agents competently;
- know how to provide psychotherapy appropriately;
- be able to find and use community resources;
- know effective ways to refer patients to psychiatrists or to other mental health specialists.

Medical Education and Issues of Hierarchical and Stereotypical Attitudes in the Profession

As part of developing diagnostic and therapeutic acumen in the area of mental health, primary care physicians should learn to accept the patient's expression of affects, and to respond in a therapeutic way. They also need to learn how their own affective responses can be used to enhance their working alliance with patients as well as how they interfere. Physicians' understanding of their own individual psychosocial development within their particular family context can be an important source of self-knowledge and understanding of others. Medical schools should provide students with experiences and opportunities to learn how to deal effectively with patients' expressions of affect.

As students explore the process of communication, they learn how emotions are communicated and experienced through tone of voice, speech inflection, facial expression, and the nuances of body language. They learn how this knowledge and these experiences are data to be gathered, processed, and used in making judgments and in carrying out interventions in the care of patients. Thus, many of the affective and communication aspects of the doctor/patient relationship can be taught through training in interviewing skills.

In the training of medical students and primary care physicians, psychiatrists can be helpful in countering the ubiquitous social and cultural stereotypes about certain groups in our society which tend to interfere with their medical care. Many trainees need help to overcome tendencies to avoid or to demean the poor, the old, members of racial or ethnic minorities, and the handicapped, like the blind, deaf, retarded or chronically mentally ill. Sexism also is still with us. Students and teachers need to recognize that their negative attitudes reflect discomfort with that which is different. Feelings of helplessness and impotence are exaggerated in the face of the psychological, socio-economic, and interpersonal difficulties which afflict the lives of human beings for whose care the doctor now feels responsible.

Students can also be helped to recognize personal attitudes which may influence their objectivity. Self-knowledge helps
prevent distortions, conflicts and certain covert values from controlling or interfering with clinical judgments and with therapeutic relationships. Students' knowledge of developmental and familial dynamics can help self-inquiry.

Doctors have traditionally coped with feelings of helplessness through seeking more scientific knowledge. An unfortunate by-product of the search for scientific accuracy, however, has been that medicine has become over-mechanized, and perhaps de-humanized. Moreover, a status hierarchy of roles, tasks, and rewards has been built into the structure of medical education and practice, psychiatry included, which militates against primary care as such, and against humanized holistic medical care in general. Students and residents learn that it is more prestigious to spend their time on inpatient services providing care for relatively rare and complicated illnesses which challenge the scientific and technical aspects of medical care, than to work in an ambulatory setting.

This attitude is gradually changing however, and the status of ambulatory practice is improving. More emphasis is now being given to the care of normal infants, to children with problems of growth and development, to patients with nutritional problems, to those with handicapping conditions including chronic and mental illnesses. Interest is increasing in preventive medicine—including diet and exercise—and in concern for health education, including problems of sexuality, marriage, parenthood and family formation.9-12

Despite these signs of change, the traditional hierarchy remains powerful in most medical schools. Psychiatrists working in primary care settings need to recognize how the medical status hierarchy affects the general social climate as well as the specific issues of competing priorities and value conflicts in medical education and practice. In our own specialty, most state mental health departments still emphasize the care of the severely mentally ill over that of providing preventive services, and fail to take advantage of the complementarity of primary and mental health care, e.g., support for mental health staff in general hospitals or neighborhood health centers.

The Psychiatric Teacher-Consultant
In both undergraduate medical education and graduate training programs in primary care, psychiatric faculties can provide useful, practical, and relevant training experiences. In the past the ideological commitment of many psychiatrists to their particular schools of psychiatric thought and the concomitant esoteric language often have interfered with effective communication of what these psychiatrists know and can contribute. At other times, lack of humility has not let psychiatrists acknowledge what they do not know and therefore cannot contribute, particularly when they have felt unaccepted as equals by their colleagues and have then compensated for their feelings with defensiveness. At the worst, theoretical inferences have been substituted for clinical data, dogmatic assertions have taken the place of demonstration, and speculations couched in jargon have been presented as facts.

When students or physicians have not accepted psychiatric assertions and speculations, some psychiatrists have discounted the lack of acceptance by attributing it entirely to “resistance.” It is indeed true that some resistance to psychosocial dimensions of medical practice stems from the reductionistic, bio-medical model and the technocratic social role many physicians have learned as students. Therefore, psychiatrists should adapt their teaching to the values inherent in the particular setting in which they teach.

The skills needed by psychiatrist-teachers in a primary care program are similar to those of a consultant, who will be most effective in the context of an ongoing collaborative role. One of these skills is their ability to identify and to demonstrate how knowledge, principles, and techniques derived from psychiatry and psychosocial medicine can be used within the role expecta-
tions of primary care physicians and within the specific settings in which they practice. Psychiatrists are most effective as teachers when they demonstrate how inferences derived from observed behavior can be used and validated. This is also true when they elicit and encourage students or residents to draw on their inter-personal capacities to provide social support and counseling.

Psychiatrist-teachers also need to relate their teaching to the specific socio-cultural characteristics of the population groups served by the primary care program. They should be familiar with the social institutions and the resources available to these groups for support. In short, they need to trainees how to develop comprehensive treatment plans geared to the total bio-psycho-social existence of patients and their families.

As indicated earlier in the discussion of status hierarchies in medicine, the people for whom primary care physicians are usually responsible are likely to be less disabled than people seen by physicians in secondary and tertiary care. Disabilities, however, are often chronic and critically affect people's lives. Moreover, primary care physicians need to know how to help patients and their families with such life cycle transitions as childbirth, adolescence, marriage, divorce, retirement, bereavement, and dying. Opportunities for preventive psychosocial intervention and health education exist during routine visits such as for family planning, pregnancy, infant caretaker interaction and well-child care, school entrance examinations, and pre-marital check-ups.13-17

Education of all psychiatric residents in consultation-liaison work is essential. This training should not be limited to the inpatient wards of teaching hospitals, but should include assignments to outpatient and emergency services, community agencies, schools and courts.18-22 These assignments help orient the psychiatrist-teacher to focus on the strengths, skills, and coping abilities of individuals and families instead of only on their deficiencies. This perspective is a necessary balance to the usual heavy emphasis on pathology which has characterized teaching in medical schools and in psychiatric training. If such assignments have been omitted from their four-year program, psychiatric trainees should be aware of this deficiency in their education and seek further advanced training and experience in consultation-liaison work.

The teacher also needs to accommodate to the limited time that primary care physicians or team members can spend per patient contact. In pediatric practice, for example, the number of patient visits per pediatrician may vary between 27 and 38 per day23—less than fifteen minutes per patient—and the period is shorter in most family practices. Even though some visits are brief so that other visits can be longer, the primary care physician needs to carry out many time-consuming functions related to patients' visits of which the psychiatrist may be unaware. Nevertheless, many primary care physicians have learned through experience how to be concise, what to leave alone, and what requires the occasional more leisurely scheduled visit. To adapt their schedules to the mental health needs of their patients, some primary care physicians set aside certain afternoon or evening hours for more prolonged interviews. At these times, spouses and other family members may be asked to accompany the primary patient.24,25

In the area of psychotherapy, the psychiatrist-teacher should include in his teaching relationship-therapy, methods of cognitive clarification and goal setting, counseling, and the principles of behavior-oriented therapy, and should indicate their respective limitations. The teaching of psychotherapy should help trainees in primary care learn to make the most effective therapeutic use of their relationship with all patients, not just those with defined psychiatric problems. Children who have been exposed to traumatic events, including illness, need special attention and often can be helped expeditiously with expressing their feelings.26,27

Administratively, psychiatrists who supervise and teach
should be functional parts of the primary care organizational structure and are physically best located in the primary care ambulatory setting. The ambulatory setting makes it much easier for both psychiatrist and patient to maintain long-term contact with patient and family. In a family practice as well as in health centers, the patient's family members are also seen for their health care. The psychiatrist's accessibility makes informal consultation possible and facilitates assembling the family for appraisal of family interaction and its relationship to the health, illness, and treatment of any particular family member.

Teaching About Referral

Knowing when and how to refer requires the primary care physician to recognize the conditions that are best referred. Such conditions include psychiatric states which cannot be stabilized either by the doctor-patient relationship or by appropriate medication, even after discussion with a mental health consultant. Included among these states are risk of suicide, violence, or psychotic regression. Patients with complicated symptoms and family situations which require time and skill beyond those of the primary care physician should also be referred.

Primary care physicians should know how to make referrals in a positive way, with a clear explanation of why the referral is being made and what kind of help is expected, and with evidence of their continuing interest in the patients. Thirty years ago in a study report entitled The Functioning of Psychiatric Clinics in New York City the authors observed that:

...patients forwarded to psychiatry solely because medicine is "through" with them are not the likeliest candidates for cure, even assuming their illness is emotional.

...To refer a patient merely because medicine cannot help him, rather than because psychiatry can, is to tip the balance against effective treatment... To be prepared adequately, the patient must realize the nature of his own problem and the nature of the help the (psychiatrist) can offer.

...Those patients who understood the nature of their problem tended to be helped, those who came for psychiatric help tended to continue coming to the clinic for treatment... If the patient has the opportunity to discuss his referral and ask questions about it, he is in a much better position to know his own mind about the step expected of him.

...Unfortunately) the great majority of patients were ill-prepared for psychiatric treatment, capable of being helped only after disproportionate and costly outlay of time and effort, and in danger of dropping out before this outlay could be expended.

This situation unfortunately is not much better now than it was in the 1940's. It would be a mistake, however, to place all the responsibility for ineffective referrals on the primary care physician. Psychiatrists receiving referrals all too often do not make enough effort to understand the setting, needs, and circumstances of the referring physician.

The primary care physician is used to receiving a written, definitive diagnosis after a relatively brief period of evaluation from specialists to whom he has referred patients; the psychiatrist's diagnosis (however) tends to develop gradually over a relatively long period of time and to overlap treatment. There is often no clear-cut point, therefore, at which the psychiatrist can give a final summary of his diagnosis and recommendations, and consequently he often delays any communication back to the referral source. Furthermore, it is not always clear, how much information the primary care physician finds useful...

These unique characteristics of the psychiatric evaluation have sometimes been used by psychiatrists as rationalizations for avoiding communication back to the referring primary care physician. The ongoing doctor-patient relationship within primary care, however, makes it imperative for psychiatrists to maintain open communication with the referring physician.
and to couch their reports in terms that will be most useful to other physicians, consistent with the maintenance of appropriate confidentiality.

Even when referral is not indicated, the primary care physician who has established a relationship with a psychiatrist feels that he has someone to turn to if he needs guidance or reassurance in the management of some of his patients. The psychiatrist who makes himself available in this way to the primary care physicians in his community will render service far beyond the limits of his practice. He will thus strengthen the collaboration between primary care physicians and mental health professionals which is essential for optimal prevention and treatment of the range of psychiatric problems in his community.36

Undergraduate Medical Teaching

Medical schools in the United States underwent revolutionary changes following the 1910 Flexner report,37 which led to the development of biological and medical sciences curricula and added great impetus to the growth of specialization. Later, federal support of specialized research and research training hastened American medicine’s move toward specialization. Since scientific medicine was making almost all of its significant advances in tissue-based abnormalities, physicians and medical schools increasingly disregarded the personal, emotional, and social vicissitudes of sick people in practice and in concepts of illness.

Until the 1950’s, psychiatry was, therefore, an isolated specialty, almost as distant from the mainstream of medicine as state hospitals had been from general hospitals. An exception to the isolation was the Johns Hopkins University where Adolph Meyer established a psychiatric service as part of a general teaching hospital in 1912. His “psychobiology” emphasized the unity of mind and body and a holistic approach to all patients. He strongly influenced the teaching and practice of academic psychiatry in the years before World War II. Meyer and other psychobiologists not only tried to develop psychiatry as a specialty closely related to medicine, but also recognized the need “to prepare the student for the psychiatric conditions commonly encountered in general practice.”38 As the psychobiologist Franklin Ebaugh39 said in a 1932 report on psychiatry in medical education:

> The contributions of psychiatry, like those of preventive medicine, should soak through the whole curriculum. This will mean a type of training that will result in the treatment of the total patient by graduates of medical schools. . . . Behavior is just as important a part of the clinical study of a patient as the understanding of physical problems, and the two cannot be separated.40

Before World War II only about a dozen medical schools established the kind of program advocated by Meyer and Ebaugh. But during World War II, psychiatrists had opportunities to work closely with other physicians in military medicine, sharing patients and socializing together as never before. At the end of the war, as base hospital staffs and other military medical groups returned to civilian life and to medical school faculties, the psychobiological ideal of the integration of psychiatry and the rest of medicine seemed close to realization. However, although the nature of wartime psychiatric practice should have favored a psychobiological orientation for psychiatric teaching, psychoanalysis provided a more attractive and exciting paradigm for looking at man’s emotional life, along with a more systematic framework for understanding and treating many psychiatric problems.

Furthermore, psychobiology ran against the trend towards specialization, whereas psychoanalysis was made to order as a basis for specialization and soon became dominant in academic psychiatry in the United States. Although many psychoana-
lysts became interested in psychosomatic medicine and sought to maintain and strengthen their ties to the rest of medicine. Psychoanalysis generally did not become integrated into the mainstream of medicine and for the most part became as isolated in its way as the state hospitals had been in theirs. Thus, the sub-specialty of psychoanalysis reflected medicine's tendency to split the patient into component parts.

Nevertheless, the medical schools responded enthusiastically to the wartime impact of psychiatry and to the stimulus provided after the war by the establishment of the National Institute of Mental Health. For a decade or two after the war ended, departments of psychiatry grew rapidly in size, influence, in allotted time in the curriculum, and in postgraduate training. These educational efforts were largely responsible for a sevenfold increase in the number of psychiatrists since World War II, and have had similar effects on clinical psychology, psychiatric social work, and psychiatric nursing.

Despite the emphasis in teaching on psychoanalytic approaches and developmental psychopathology, and on training in intensive psychotherapy, psychiatrists also were concerned with the psychiatric components of medical problems and with teaching medical students the basics of human behavior and the psychosocial contexts of medicine. For some time after World War II it was confidently expected that primary care physicians would soon have the training and the interest to treat most emotionally troubled patients at the point of first contact, and that by then there would be enough psychiatrists to take care of the rest. But in spite of all these efforts and even though special programs for the general practitioners were sponsored by NIMH, psychiatry's impact on other physicians has remained disappointing. The dichotomy in medical education between the "physical" and the "mental" persists despite attempts to unify patient care, despite efforts to reintroduce a holistic and family-oriented approach to medical education through psychiatric consultation and liaison services, and despite instruction in behavioral science and personality development in all medical schools. Thus psychiatry's ambitious educational goals have not been attained or even approached. In fact, psychiatry's influence in medical education appears to have receded from its peak in the 1950's and 1960's.

Many factors have contributed to this phenomenon, of which five seem most important:

1. The isolation, idiosyncratic practice style, and lack of conventional validation of psychoanalysis;
2. The increasing reliance on the laboratory for medical diagnosis and on biological treatment methods;
3. The clinical teaching emphasis, using patients who are hospitalized on specialty and sub-specialty services, in which the interdependence of the biological and psychosocial is seldom stressed;
4. The gap between primary care physicians and specialists which is especially wide in teaching centers where specialists not only dominated the education, but also often opposed hospital privileges for general practitioners;
5. The failure to make behavioral science teaching sufficiently relevant to clinical medicine in the pre-clinical years, and the current biological and chemical emphases in psychiatry which tend to play down issues of psychosocial development and family concerns in medical care.

As Turnbull suggests:

... nothing will make behavioral science relevant and meaningful to students until they see its application (and can) appreciate how it is helpful to the practicing physician.

With the current upsurge of interest in primary care, psychiatry has a new opportunity to influence medical teaching.
Psychiatry's opportunity arises from the fact that much of the strength of primary care as well as its attractiveness lie in its emphasis on the whole person, on family relationships, and on continuity of care rather than on the drama of the hospital-based specialties. This teaching opportunity can be implemented in the clinical clerkships and also in the pre-clinical years. In actual practice, physicians deal with patients' personal and family problems because patients expect them to, and such problems represent a considerable portion of their work.

Departments of family practice must adapt as best they can to the block system which is characteristic of most medical school curricula, or must concentrate their teaching in the pre-clinical years, or must attempt to effect changes in the entire curriculum. In the next few paragraphs, these different modes of instruction will be discussed as they apply to family practice.

Clinical Clerkship

The evident and dramatic pathology, the capacity for flexible scheduling, and the longer time for patient work-ups all contribute to the tendency to concentrate medical school clinical teaching on hospitalized patients. However, in order to bring home to students the significance of the contexts of clinical encounters and of the patient's life situation as well as continuity of care, teaching in primary care ideally should be distributed over an extended period of time rather than clustered in one full-time block. In block scheduling, it is hard for students to experience ongoing relationships with their patients. The major teaching assignments in most departments of internal medicine and pediatrics are on inpatient services, and primary care experience, if required at all, is usually condensed into a portion of an out-patient clerkship.

A clerkship that strongly emphasizes ambulatory care can reflect the essence of family practice. Ambulatory clerkships may be located either in family practices or in community practice preceptorships. However, experienced and willing teachers are not easy to find in community practice. Psychiatric input is usually welcomed by academic family practitioners, but is generally more difficult to include within community teaching settings.

Since family practice and psychiatry share an emphasis on personal and family relationships and continuity of care, the two departments may find it advantageous to combine their forces and their time in the clinical curriculum in a single ambulatory experience that integrates teaching in both disciplines. We believe that experiments in collaborative clerkship teaching can make the subject matter of both specialties more attractive to students.

Teaching in the Pre-Clinical Years

Family practice or primary care can be taught in the pre-clinical years either independently or in conjunction with the teaching of human behavior or physical diagnosis. Continuity of care can be more readily illustrated in pre-clinical teaching, which can be spread out over an extended period than in a block clerkship. It is also logical to teach primary care early, because in the community primary care is provided before specialized care. In addition, early clinical exposure can screen out students with an over-idealized view of family practice who may not be temperamentally suited for family practice.

Since the emphasis in teaching primary care during these years is on the psychosocial components of practice as well as on the biological aspects, pre-clinical primary care courses provide ideal opportunities for psychiatrists to undertake collaborative teaching. To make the best of these opportunities, psychiatrists must recognize that their task is not to recruit psychiatrists but to respond to the needs of future practicing physicians. Consequently, they should teach brief practical diagnostic and treatment techniques, and should emphasize
the family as well as the individual as possible loci of disturbance.

The pre-clinical years are important for the inculcation of future professional roles in medical students. The clinical faculty provides models of how to relate to patients and how to think about patient care, and teaches basic attitudes toward medical practice. Teachers should make sure that the emphasis on technology is balanced by humanistic concerns, and that the patient is regarded as a responsible collaborator rather than a passive recipient of prescriptions based on technical know-how and skill. Teachers should also emphasize that the patient is considered to have family relations which are important to his well-being, rather than being treated as an isolate in time and place. These are the years when medical students prepare to become doctors, and the professional models they encounter have great impact on them.

**Major Curriculum Changes**

Several medical schools have undertaken substantial curriculum revisions, partly in response to the developing interest in primary care. Some of these revisions have provided separate tracks for primary care and other major areas of interest, as at the University of Washington. In others separate primary care teaching settings have been established, as at branches of Michigan State University and of the University of Illinois. Psychiatry and psychiatrists have fitted into these innovative approaches to medical education according to the special circumstances of each setting.

Psychiatrists can make substantial contributions in all these teaching formats if they accommodate themselves to the new setting and, after negotiation, accept mutually agreed-upon limits as to what is expected of them. To reiterate the theme of this chapter, it is crucial to the success of psychiatrists’ participation to make sure that their contributions are relevant and applicable to primary care practice as it is being taught by the parent department. Furthermore, psychiatrists must be familiar with consultation practices and the various consultant-teacher roles appropriate to particular primary care settings. Some programs in which psychiatrists participate in undergraduate education are cited in the appendix.

**Residency Training in Primary Care**

The time allotted in primary care residencies for training in psychiatric and psychosocial aspects of primary care varies widely. The American Academy of Family Physicians (AAFP) recommends that approximately 16 percent of the total training time—the equivalent of six months of a three-year residency—should be allocated to this component. Pediatric and internal medicine residency programs usually devote less time to the psychological and emotional aspects of patient care. Learning opportunities for these residents are often limited to the psychiatric consultations they request for their own patients. We believe these residents would learn more if mental health collaborators were integrated into the teaching staff.

**Training Methods**

As in all clinical training programs, teaching content and method should be integrated into clinical experience that is geared to the trainee’s level of knowledge and need. In one method the psychiatrist/teacher sits in the examining office with the primary care resident during clinical contacts. Other methods include closed circuit TV, videotaping, case conferences, and informal, brief teaching episodes occurring between patient contacts.

Role-playing and patient stimulation, both live and on videotape, help residents to explore and to develop their individ-
ual styles of interaction with patients. Residents who take patient roles can experience something of what it is like to be on the other end of the doctor-patient transaction. In role-playing and simulated interview situations, the psychiatric and primary care faculty as well as the trainees should be willing to play roles (see appendix).

A particularly effective teaching method uses faculty members, who are primary care physicians, as role models to demonstrate clinical interviews on videotape. As the tape is played, the primary care teacher discusses how the theory about the psychosocial aspects of patient care has been integrated into the interview technique. In this format the psychiatrist/teacher serves as a resource person, commenting on the ways the primary care teacher develops and maintains a relationship with the patient. The psychiatrist/teacher may focus on the patient’s anxieties or realistic concerns, on the primary care teacher’s skills in eliciting information and in achieving patient compliance with any regimen prescribed, and on the psychosocial factors within the physician and patient which impede effective treatment. The psychiatrist attends to the patient, the doctor and the student, but it is the primary care teacher, concurrently modeling psychosocial concerns as well as biomedical skills, who has the most powerful impact on trainees. Effective input from the psychiatrist/teacher should result in primary care teachers—and teachers of behavioral medicine and behavioral pediatrics—ultimately replacing psychiatrists as the major teachers of mental health in primary care.

In recent years, training programs in behavioral medicine* and pediatrics have been organized for residents and fellows in their respective parent departments. They are intended to develop in-depth knowledge and skills in the diagnosis and treatment of common psychosocial disturbances that are seen in the practice of internal medicine or pediatrics. Psychiatrists

*The term “behavioral” is used in a general sense and is not meant to be construed as indicating adherence to behavior theory or treatment techniques.

are often significantly involved as teachers and supervisors, although program directors and primary faculty are pediatricians or internists. Some of the graduates of these programs may well form the next generation of mental health teachers in primary care programs.

Home visits with primary care physicians, and, when indicated, with psychiatrists, are other important opportunities to learn about the psychosocial parameters of medicine. They offer chances to view and experience family interaction “in vivo” and they help trainees to appreciate the practicality and other aspects of a recommended treatment regimen which may not be evident from contacts limited to hospital or clinic settings.

Continuing Education and Staff Development

Continuing education programs offer opportunities for formal and informal group interchange over a condensed time period. The workshop or short course usually is built around a specific topic or theme presented by one or more experts, using a variety of teaching methods. The methods include lectures, audiovisual aids, and such experiential modes as role-playing and expressive or affect-oriented task groups.

Planning and carrying out effective workshops or seminars require careful attention to goals, content, method, and known or assumed needs of the learners. Lectures should be brief, well organized, and accompanied by hand-outs, reprints, and a manageable, easily available bibliography. Slide shows should be carefully edited, since their sedative effect can be even greater than that of long lectures.

Experiential methods provide the opportunity to try out “in vitro” new behaviors which may be integrated into the “vivo” of professional practice. These methods should be carefully selected with due concern for the connections among goals,
content, and procedure. Leaders of experiential sessions should be well trained, not only in group process and dynamics but in content. Methods which deliberately mobilize affect as the major teaching-learning method, such as T-groups, confrontation groups, and marathons, pose emotional hazards in workshops of short duration. Brief, intensive, affective explorations and purgations rarely produce significant, positive, or enduring change in the personal or professional styles of the participants. On the other hand, when the participants are properly prepared, careful experiential work fulfills the task of continuing education to help the learners improve their professional knowledge, skill, and attitudes.

Continuing education in the form of staff development and in-service training in a health care group setting or agency can be episodic or continuous, and can be explicitly planned or informal and fortuitous. Much valuable education occurs through continuous informal assimilation, when people who work together share concerns about diagnosis, treatment, rehabilitation, and social support of individual patients and families.

More formal training may be provided by either the psychiatrist or mental health specialist who serves as part of the primary care team, or by outside experts brought in for the occasion. The advantage of “in-house” experts is that they have established relationships with the staff and know firsthand the kinds of problems presented by the particular patient population served by that program. The staff psychiatrist also knows the strengths and weaknesses of the staff in providing effective psychosocial care, and can therefore focus on idiosyncratic training goals and needs. The disadvantages of using the “in-house” psychiatric staff are inherent in the fact that they are well known and that everyone on the staff may consider that they have already heard or learned all that such psychiatrists have to offer. Familiarity, which is helpful in day-to-day working situations, may induce boredom when the team psychiatr-
THE PSYCHIATRIST AS COLLABORATOR
IN PRIMARY CARE PRACTICE

Thus far in this report we have concentrated on education in
the psychosocial aspects of primary care for the physician who
will practice alone, or in partnership, or in groups with other
primary care physicians. Most of these physicians will have
access to psychiatric consultation and to psychiatric treatment
for the patients they refer, but the consultant psychiatrists and
the referring physicians will not be as closely related as they
would be if they were both integral parts of primary health care
entities.

On the other hand, if mental health care and general health
services are integrated administratively, primary health care
personnel have ongoing psychiatric collaboration, consulta-
tion and treatment consistently available to them as they care
for the emotional aspects of their patients’ illnesses. The ease of
integration and access to consultation possible in integrated
settings should facilitate early detection and treatment as well
as appropriate referral practices.

In spite of its evident advantages, the integration of health
and mental health delivery systems has not been easy to achieve.
One reason for this failure has to do with responsibility. The
treatment of serious mental illness has traditionally been a
responsibility of government. General health care, however,
until recently has been a jealously guarded prerogative of pri-
vate practice, with the government’s responsibility limited to
prevention and public health measures, to the care of veterans
and military personnel, and to the care of some of the indigent
population as well as such categorical handicaps as blindness.

In the public sector, this division of care has been responsible
for the creation of parallel and separate bureaucracies for
health and mental health systems at local, state, and federal
levels. Within these bureaucracies mental health professionals
have worried that integrated public programs would decrease
their budgets, and public health officials have worried that in
any merger they would be dominated by the larger mental
health bureaucracies. Furthermore, many mental health profes-
sionals view medical care in general as disease-focused, im-
personal and more concerned with the laboratory than with the
person, especially in teaching hospitals, whereas many physi-
cians view the mental health disciplines as “soft” and unsci-
entific, as well as scarce.

In recent years, renewed efforts to reduce some of these bar-
riers to integrated care have been made in some types of primary
care systems. Health Maintenance Organizations (HMO’s) and
neighborhood health centers have introduced new types of
health care programs in which mental health and primary care
personnel collaborate closely. Some of these programs will be
described.

Private Primary Care Practice In
Collaboration With Mental Health
Personnel

In a few settings, privately practicing mental health personnel
and primary care physicians have worked out collaborative
relationships. They include fortuitous associations resulting
from personal friendship, shared office space, or billing per-
sonnel. In other instances a psychiatric social worker or psy-
chiatric nurse has been employed by a solo practitioner or a
partnership, and a few groups that provide primary care em-
ploy psychiatrists to provide both consultation and treatment.
These arrangements tend to be idiosyncratic and their charac-
teristics depend on the specific circumstances and personalities; few have been reported in publications.1

The initial enthusiasm for community mental health services included the hope that privately practicing primary care physicians would seek out opportunities to use the consultation and education services mandated by the Community Mental Health Center legislation. Although many physicians have referred patients to the Centers, the hope that they would use the consultation services of these Centers to improve their mental health skills has rarely been realized. One such instance was an experiment undertaken several years before the Community Mental Health Centers Act by Kiesler in a rural area of Minnesota. He accepted a mental health program position with the stipulation that he would not carry out any direct treatment, but instead would devote all of his efforts to consultation and indirect service, assisting the physicians in his area to carry out the mental health care of their patients. Since there were no other psychiatrists within commuting distance of this rural area, he was able to carry out his program for more than twelve years, and the primary care physicians and their emotionally troubled patients appeared to benefit. The pressure by these physicians for the consultant to provide direct services was unrelenting, however, and in recent years the program has become more conventional.2

Another program of psychiatric consultation to community physicians was developed in 1964 by the North Carolina Department of Mental Health and continued for many years until political considerations led to its demise. Its purpose was to bring psychiatric assistance to the four million persons who live in the state's rural and semi-rural areas. It started as a way to help community physicians provide aftercare to former mental hospital patients, but it was expanded to offer consultation to physicians about other emotionally disturbed patients. Five counties were selected for the project, and 58 of the 64 physicians in these counties agreed to participate. At the outset, the consulting psychiatrist spent a great deal of time gathering relevant information about the counties, their power structure, the interaction among their agencies, and the relationship of the local physicians with these agencies. He then established a consultative relationship with each physician, making himself available for emergencies and difficult problems, dealing with the issues they presented, and gradually introducing psychiatric principles within the context of case discussions.

It quickly became apparent that much of the program's success would rest on the ability of the consulting psychiatrist to gauge the attitudes and interests of each participating physician, and on his capacity to translate psychiatric knowledge into practical and acceptable ideas that the physician could use in his daily practice. In time, the psychiatrist worked out a regular circuit and sent a copy each month to each doctor, so that he or she could reach the consultant at any time by telephone. This accessibility of the consultant did much to persuade the doctors to accept the responsibility for treating patients whom they would formerly have referred to special treatment centers. Patients requiring rehospitalization were treated by the primary care physicians on the general medical wards of local hospitals; during the project psychiatric admissions increased from 10 percent to 30 percent of all admissions to these hospitals. The project's success has led to its expansion to other areas of the state, and rotation through the program was made an integral part of the psychiatric residency programs of three of the state's training centers. Physicians in the group have affirmed that as a result of the program, the emotional problems of patients seemed less formidable.3

Both the Minnesota and the North Carolina programs required the psychiatrist in his consulting services to respect and to adapt to the special work situation of community physicians and to their capacity for extended care of their patients. Both projects also required continuous involvement of a mental
health professional with the same group of physicians over an indefinite period of time.

A long-term project for the training of British general practitioners in psychiatric interviewing and treatment was devised by Balint et al.1 In their program, a small group of physicians meets regularly with a psychiatrist, usually weekly, to discuss their psychotherapeutic interventions with patients in their practices and to share reactions to and feelings about these patients. Balint held that doctors have a vague but firm idea of how a patient ought to behave when ill which they tend to impose upon patients. In the seminars, Balint would elicit expressions of the doctors' individual ways of dealing with patients because he felt that most doctors are adaptable enough to allow a variety of relationships to develop between themselves and their patients. In this way Balint encouraged the physicians to adapt habitual responses to their patients' individual needs.

The term “Balint group” has been given to on-going, usually weekly, group seminars led by a psychiatrist in which primary care physicians or specialists discuss their patients' feelings as well as their own feelings about their patients. Although aimed at enriching primary care practice, seminars of this kind run the risk of encouraging participants to become psychotherapists for some of their patients, instead of psychiatrically-oriented primary care physicians for all of their patients. Their psychiatrist-leaders should be careful, therefore, not to use the groups as recruiting grounds for psychiatric training. Balint groups are more popular in Europe than in the United States.

An unusual approach to mental health collaboration with primary care physicians was instituted several years ago by means of a two-way closed-circuit television link between physicians in a small, often snowbound, Vermont town and psychiatrists at Dartmouth Medical School.5 Although the consultations appeared to be effective, the unit costs were too high for

the project to continue after the initial grant was exhausted. The increasingly efficient use of tele-communication in medicine augurs well for the future use of this approach in collaboration, especially for primary care physicians in remote areas.

The field of general pediatrics offers special opportunities for mental health collaboration in the primary care of children with emotional, behavioral, and learning problems, and various informal collaborative arrangements have been made between child psychiatrists and other mental health professionals with pediatricians.6

### Primary Care Centers In General Hospitals

The non-emergency use of hospital emergency rooms increased rapidly in the 1950's and '60's, especially in inner-city hospitals located in areas where medical care was minimal. Even when out-patient clinics were available, as in university hospitals, their restricted hours, long waiting time, fragmented and impersonal care, and often higher costs led many patients to prefer to use emergency rooms. In response, the hospitals, whose emergency facilities have become overcrowded, have sought to enlarge their ambulatory facilities by instituting week-end and evening medical and pediatric clinics, and by making their regular weekday clinics more attractive and personalized.

Recently, the rise of family practice and its need for teaching settings have led some university medical complexes and community hospital training programs to develop family health or primary care centers. These centers put considerable emphasis on the psychosocial aspects of primary care, and on the healthful development of individuals and families. As described in the earlier section on training, many centers have established collaborative relationships with psychiatrists and other mental health personnel as staff members. Service needs stimulated the
creation of some centers and educational goals in others, but in
virtually all of them the two missions became combined.

The role of the psychiatrists in the primary care center is that
of consultant and educator. They are less concerned with direct
patient care than with helping primary care givers to identify
and to treat patients' psychiatric problems, to heighen staff
awareness of how psychosocial factors influence the course of
illness and its resolution. One example is the Beth Israel Hos-
pital Ambulatory Care Center in Boston, which was estab-
lished in this teaching hospital in 1972 primarily in response to
the increased demand by neighborhood residents for non-
emergency care in the emergency room. As described by
Schniewind,

... patients seeking primary medical care at this center are
served by eight small teams, each consisting of a physician,
nurse-practitioner, social worker, receptionist, nutritionist,
and health assistant. House staff and medical students are
regularly assigned to work with each team. Clinical and ad-
ministrative support is provided by a seven-member "core
team" made up of the medical administrators, psychiatrist,
research adviser, the social service coordinator and the assist-
ant director of nursing for ambulatory care. The center's
activity comprises about 50,000 visits per year.

The psychiatrist is paid by the Ambulatory Care Center,
where his office is located. Thus, he shares tangible and intan-
gible space with the medical staff and works with them in a wide
variety of settings such as clinical, teaching, and administra-
tion. Half of his time is spent in direct, reimbursable patient
services and the other half in providing such indirect services as
consultation, staff education, clinical conferences, joint inter-
views, home visits, emergency consultation, administration,
planning, and research. Since each patient already has a physi-
cian or nurse as primary health care provider, the psychiatrist
does not function as a primary care specialist. Initially,
Schniewind had planned to offer only consultation to improve
the health care staff's mental health skills, but later added direct
care for patients who would otherwise have to be referred to
outside resources. He found that his direct care lent validity to
the function of consultation.

Schniewind believes that success in a project of this kind
requires the psychiatrist first of all to get and retain the active
support of the program director. Visibility and relationships
with other physicians are helped by regular participation in
peer review and other conferences and by always being avail-
able. Spontaneous consultation is facilitated through team
meetings and regular contacts with each team social worker.

Although Schniewind's experience reflects some idiosyn-
cratic characteristics of the Beth Israel Center, it contains many
aspects of general validity that can be helpful to psychiatrists
preparing to work in any primary care center. This type of
program is also well suited for medical students and residents
to learn comprehensive patient care if assigned for a suffi-
ciently long period of service.

Prepaid Health Care: Foundations And
Health Maintenance Organizations

Health care comes in many formats. Prepaid group practices
(PGP's) such as the Kaiser-Permanente plans usually provide
care in their own clinics, while the so-called medical care
foundations or independent practice associations, as they are
also called, arrange for prepaid patients to be seen by physi-
cians in their private offices. Most providers of prepaid health
care depend on group enrollment from industries, government,
schools and colleges, or other organizations. Enrollment of
members occurs in a variety of ways, most commonly through
contracts with employer groups, many of which offer em-
ployees a choice of an insurance package or a prepaid plan.
Prepaid group practices may become Health Maintenance Or-
Organizations, defined by the (HMO) Act of 1973, if they meet
certain specific requirements, including the provision of specified mental health services.

PGP’s are attractive because they provide comprehensive clinical care and continuity over long periods of time for all members of a family, and because they provide almost all health services in a single health center or service network. The disadvantages are those associated with organizational services in general: they may be cumbersome, and freedom of choice or access to specialists is limited. A high level of care, however, is promoted by institutional pressures for quality, and a stake in fiscal efficiency favors efforts toward prevention.

Medical care foundations preserve the traditional format of private practice by individual physicians and groups and, compared to PGP’s are more likely to maintain traditional methods of referral of patients to psychiatrists and other specialists. They are similar to PGP’s in that they must assure provision of a comprehensive range of high-quality services and continuity of care, and also by their use of a pre-payment mechanism and commitment to control health-care costs. Practice in widely separate offices makes referral and coordination of care more difficult, and provisions for mental health care are often minimal.

Mental health services were not included in the basic health benefits of early PGP’s. Two of the early and currently largest plans in the country—the Kaiser-Permanente plan and the Health Insurance Plan of Greater New York (HIP)—first offered mental health benefits through a supplemental rider available to subscribing groups as an option for an additional monthly payment. Until 1978, however, only about one-fourth of both Kaiser and HIP members elected mental health coverage. In 1978 the Kaiser plan became an HMO, and now must provide mental health benefits to all enrollees. (HIP, now also an HMO, was described at some length in an earlier GAP report on methods of payment for mental health services.)

A compelling reason for a PGP or a medical care foundation to become qualified as an HMO is the federal law that requires all organizations employing more than 25 persons to offer their employees the option either of a conventional health insurance package such as Blue Cross, Blue Shield and Major Medical, or of membership in a federally qualified HMO if one is located in the employment area. The so-called second generation PGP’s, in order to qualify as HMO’s, must now include mental health care as a basic benefit but with limitations on the extent of treatment.

The PGP offers many opportunities for innovative as well as conventional use of psychiatric approaches and for development of new methods in reaching patients who previously had no access to such care. The key element in the PGP as a mental health resource is the primary care clinician who continues to manage the care of about 75 percent of patients with emotional problems, referring the rest to psychiatric care. The decision to refer, however, may be based not so much on the nature of the psychiatric disability as on the time required for care and the complexity of the management problem. Many PGP patients with diagnoses of schizophrenia or endogenous depression can be treated by primary clinicians if the medication schedule has been established psychiatrically, or if patients respond well to the primary care physician’s medication efforts.

The Kaiser-Permanente plan, as an example of first generation PGP, and the Arizona Health Plan and Community Health Care Plan of New Haven, as examples of second generation programs, will be reviewed in the next sections.

1. The Kaiser—Permanente Health Care System has an overall membership of about six million enrollees, most of whom live in California or other Western states. The system’s first cautious steps in psychiatric treatment services were taken at the urging of unions in the late 1950’s and were restricted by an array of limitations and exclusions. The concerns gradually subsided, however, and the number of membership groups
requesting psychiatric benefits rapidly increased until in 1978 the plan became an HMO and psychiatric benefits for all enrollees were required.

The potential of PGP’s for innovation in identifying the need for mental health services is illustrated by the local Kaiser-Permanentene Plan in Santa Clara, California. This plan, with an enrollment of 170,000 has been conducting an experimental systems approach to mental health care with 5,000 new members. The approach was based on early screening and identification of health problems through automated multifaceted health testing. After screening, all patients in the experimental group were informed in groups on how to use the facilities of the plan, and then were given a health education program. Four categories were established:

1. Well/Well: no physical findings and no complaints
2. Sick/Well: significant findings but no complaints, as in hypertensives
3. Well/Sick: no significant findings, but complaints—the “worried well”
4. Sick/Sick: significant findings and complaints

The Well/Sick are considered at risk for the development of mental health problems. They are examined by nurse-clinicians who look for evidence of psychological or emotional problems. If appropriate, patients are referred to treatment or educational programs intended to help them deal more effectively with their perceptions about health and illness, and to teach them to use social strategies other than physician visits or tranquilizers to reduce stress. The Sick/Sick are referred for traditional appropriate care.

There is also a special clinic for medical review of individuals with complex interwoven physical, psychophysiological, and psychosocial problems. The program at Santa Clara is significant in that it attempts to introduce mental health services in an established HMO along the lines of the public health model of screening, case identification, establishment of a continuum of health services, and problem-oriented programs of health education.

2. The mental health component of the Arizona Health Plan is oriented towards referral to specialized mental health services rather than towards treatment by primary care personnel. All of its members are covered by a mental health benefit package, under which a member may receive 20 out-patient individual, couple, or family therapy visits, or, as an alternative, 40 group therapy sessions per year. Thus, the benefit package limits the Plan’s responsibility either to treatment of emotional problems responsive to time-limited interventions, or only to the early phases of longer term treatment.

Referrals to the psychiatric service are usually made by primary care personnel in somewhat the same way as in the Santa Clara plan. The referral process begins with a multi-phasic health screening examination. If evidence of a mental health problem is uncovered, the patient is seen by the mental health professional and is referred back to the primary panel following completion of treatment or consultation. Patients are evaluated to determine if their psychiatric needs can be met either on a short-term, goal-oriented basis, or on an infrequent, periodic basis over an extended period of time. If not, the patient or family is referred to an appropriate community service or to a private psychotherapist. The plan does not assume financial responsibility for these referrals. As in other primary care settings, the psychiatrist works as part of a team of mental health and medical professionals and must adapt to the fiscal realities and limitations of the plan.

3. Community Health Care Center Plan of Greater New Haven is an example of a small plan which emphasizes mental health care by the primary health care team. The plan has an enrollment of about 25,000 persons. Its primary care program is
built around small teams, led by internists or pediatricians who are also on the faculty of the Yale University School of Medicine. Each team is made up of two physicians, a physician-assistant (in medicine) or a nurse-clinician (in pediatrics), a mental health clinician (who may be a psychiatric social worker, psychiatric nurse-clinician, or clinical psychologist), a medical aide for each physician, and a team receptionist. Each physician and physician-assistant has an assigned panel of patients, and the team arrangement is thus intended to provide administrative support for what is in effect a group of solo practitioners. Consultation is frequent within the team as well as with surgeons, obstetricians, orthopedists, neurologists, and other specialists in the plan. The services of a psychiatrist are also available as a team consultant and for treatment outside the team structure.

This arrangement gives primary clinicians the opportunity for day-to-day consultation and collaboration with their team mental health clinicians as well as ready access to the services of the back-up psychiatrist for special problems. Regular consultations help primary care clinicians to focus on the importance of the patient’s personal and family relationships and to assess the impact of adverse life situations in causing distress and disorder. Thus, the plan provides a working arrangement for continuing education, consultation, and collaboration on mental health problems.

**Neighborhood Health Centers**

Neighborhood health centers have provided new and creative models of integrated health and mental health services. They are community-based facilities supported by federal or local funding, and usually are devoted to the health care of the poor or hitherto medically underserved populations. These centers were originally funded by the Office of Economic Opportunity as part of the war against poverty and later by the Department of HEW. By 1971 these grants supported Neighborhood Health Centers located in 120 different communities in 42 states, serving an estimated 1.3 million people in 1974. Other health centers were developed by adding new services to such categorical programs as Title V—Maternal and Infant Care, or Children and Youth Projects.

These health centers have been sponsored by hospitals and medical schools more often than by local governments. Although each program has characteristics of its own, each has in common a family and community orientation with citizen participation both at the board level and at the staff paraprofessional level, and an emphasis on continuity of care, service coordination, and team health care.

As with many other innovative programs in the war on poverty, federal funding for neighborhood health centers has been reduced, as the over-reach of the 1960’s was followed by the retrenchments of the 1970’s. Other problems have included conflict over community control, difficulties in getting professionals to work in teams, high staff turnover, and, in many cases, limits to the range of services provided. Much of the broad mandate has never been fulfilled, but an important part of the primary care movement in this country has grown out of these programs. The major impact of the centers has been to remove barriers to health care for the poor and to give the population served an opportunity to participate in decisions about their health care.

The health centers at first concentrated on basic pediatric, adult medical, and obstetrical services. Mental health in general and psychiatrists in particular often were viewed with suspicion in the communities and were not at first included. In fact one of the earliest and best known of the Neighborhood Health Centers, the Martin Luther King Center in New York City, prided itself on eliminating mental health professionals entirely in favor of community para-professionals. Patients with obvious signs of mental illness either were referred to
separate agencies or were served by primary health care staff without adequate consultation.\textsuperscript{21}

Most centers, however, gradually developed mental health services in response to the growing interest of citizen boards and the efforts of mental health professionals. At first, most of the centers were traditional in their approach to mental health, using a mental health professional who would consult with health care staff about problem patients and would suggest referral to outside mental health facilities if indicated. This function resembled that of the hospital liaison psychiatrist, and was not successful for two reasons. The patient often did not want to go to a separate mental health facility for care, and the referring staff was dissatisfied because the mental health staff did not carry out direct treatment in the centers, let alone report back to them.

Other neighborhood health centers developed departments of mental health which, although component parts of the centers, were still isolated in separate enclaves or subsystems. Since the mental health sections were entirely dependent on the medical staffs for referrals, they often missed opportunities to intervene at early stages of problem formation because the referring staff did not accurately identify the problems. It soon became clear to these centers that when mental health professionals are present but not integrated into the family health care team, they miss many informal opportunities to strengthen the team's mental functions and performance.

By contrast, in eight of the nineteen neighborhood health centers described by Borus et al.,\textsuperscript{22} inter-disciplinary teams consisting of health, mental health, and social service staffs were used to coordinate planning and care, to facilitate inter-departmental referrals within the health care center when needed, and to promote a multi-dimensional perspective of patient care. Inter-disciplinary collaboration in these centers helped to prevent either too broad or too narrow a definition of mental health problems by the general health staff. Too broad a definition resulted in "dumping" all difficult cases onto the mental health staff with unrealistic expectations about treatment; too narrow a definition resulted in failure to refer patients with serious mental illnesses.

Among all of these 19 neighborhood health centers, two-thirds of the total mental health program hours were spent in direct service to patient or family and one-third in indirect service. About half of the direct service hours were spent in evaluation and referral, and the other half in treatment, which included crisis or brief treatment (43%), long-term insight psychotherapy (24%), supportive aftercare (18%), and family and couple therapies (15%). Most of the indirect service hours were spent in consultation, education, treatment and program planning with neighborhood health center staff. The remaining time was devoted to inservice training and supervision of the mental health staff, preventive services, and consultation to other neighborhood programs.

Almost half of all referrals to the mental health programs were made by the general health staff. A quarter were self-referred or referred by their families or friends, and most of the rest were referred by other neighborhood agencies. Although, generally, children and adolescents constitute an underserved population in mental health services, it is noteworthy that 43 percent of patients seen by the mental health staff of the neighborhood health centers were under 18. Integrated services to the elderly were also improved because health center staff in a neighborhood location were more likely to make visits to the homes, residential apartments, or nursing homes where the elderly live.

In one of the neighborhood health centers, one-third of the patients received all of their mental health care from a health care professional, and 15 percent of patients at the center were given psychiatric diagnoses. Over 5 percent of the total community population used the services of the mental health staff, almost three times the estimated yearly utilization rate for
outpatient mental health services in the United States. This high utilization reflects the acceptance of these mental health services by the community, their accessibility, and the ease of referral by primary health care personnel. Separated or divorced adults, children, and patients from public housing census tracts were all significantly over-represented in their use of mental health services.\textsuperscript{25}

The mental health programs in the 19 neighborhood health centers appear to complement rather than to compete with local community mental health center programs, and together they provide a broad spectrum of mental health care. In line with the mandate for community-based mental health care, the neighborhood health care programs provide frontline ambulatory services that are geographically, culturally, and psychologically accessible. The association with general health services increases opportunities for preventive intervention, early detection, and long-term supportive aftercare. It also provides a relevant setting for the evaluation and treatment of psychosomatic illnesses, which have proved difficult to treat in categorical mental health settings, partly because those patients resist dealing with their illnesses in psychological terms. When mental and physical health practitioners work together, it is easier to avoid reinforcing the patient’s tendency to split mind and body.

On the other hand, the community mental health center programs are better equipped to provide the more specialized and expensive centralized services, such as in-patient and day hospital care or addiction programs. The primary care mental health units must be effectively linked to these backup centers so that referrals are respected and patients can move easily between care systems.

The neighborhood health care center encourages all three types of preventive psychiatry. “Primary” prevention, or mental health promotion, is a natural part of the health or human services system which provides services with a family focus, including family planning. The center provides secondary prevention through its availability during crises, and through providing an opportunity for early intervention and referral. It provides tertiary prevention, including rehabilitation in a non-psychiatric facility that makes it easier for many de-institutionalized patients to stick to a follow-up regimen, which will reduce the likelihood of re-hospitalization. The neighborhood health center cannot guarantee compliance with follow-up treatment, but its setting and ambience are more acceptable to many patients than independent psychiatric programs.

Evaluation And Accountability

All of the primary care programs we have described stress evaluation in the interest of quality and efficiency, and considerable emphasis is placed on reducing the amount of time subscribers spend in general hospitals. It remains to be demonstrated, however, whether these and other prepaid primary care programs as well as neighborhood health centers can affect a significant reduction in psychiatric hospitalization and re-hospitalization.\textsuperscript{24-27}

For a variety of reasons psychiatry has been slow to develop satisfactory evaluation methods for its ambulatory services. Psychiatrists have long been skeptical about outcome studies, which measure only relief of symptoms and improved functioning, because their treatment goals are often subtle and profound, and intended long-range changes cannot easily be measured at any one point in time. They have also been concerned that treatment aimed at maintaining a patient’s functioning or at preventing deterioration could be assessed as “no change” with a negative connotation. Although these considerations may seem valid to psychiatrists, they do not necessarily convince fund providers who must weigh budget priorities. Psychiatrists must recognize that in a world of limited resour-
ces cost containment policies are a fact of life as is the prevailing skepticism and ambivalence about the value of mental health practice, which is shared by primary care staffs and administrators. If mental health services are to become a major component in these programs, evaluation methods must be developed which can demonstrate quality, effectiveness, and efficiency. 28-35

The medical record is an important data source for evaluation. Consistent with confidentiality principles, psychiatric records must render evidence of treatment and treatment effects. The problem-oriented record is gaining in acceptance and is quite compatible with mental health practices in primary health services. Whatever method is used, the records must provide adequate data that include treatment plans with stated goals and objectives, progress notes for each visit, medication records, periodic review notes, and termination notes. Adherence to desirable protocol standards requires regular record review to ensure completeness and timeliness.

There are two major categories of evaluation: process and outcome. Process surveys in mental health programs should include: supervision, peer review, and audits, or special studies on problem areas in providing services. The use of a management information system permits data retrieval regarding problems presented, demographic profiles, diagnoses, and type of service provided. Utilization review in mental health has been employed for the most part in in-patient settings, but is being extended to out-patient services as consensus on standards is achieved. 35-38

Outcome criteria have developed slowly in mental health because it is so difficult to decide upon measurable outcome parameters—whether to use symptoms, interpersonal functioning, social functioning, or other criteria. The measure most widely employed is the Global Assessment Scale (G.A.S.). A good deal of research in this area is still needed.

The mental health resources in all of the primary care pro-

grams are limited, and so mental health personnel must define their goals or objectives clearly. Crucial questions to be considered include the characteristics of the target population, program priorities and service limitations. An evaluation system helps to determine whether scarce resources are being used in a planned and rational manner. Unit cost factors must be taken into account by psychiatrists in recommending realistic and cost-effective treatment strategies in primary care settings. Treatment emphasis may or may not be placed on measurable symptom relief and improved function, but goals should be made explicit even if progress towards them cannot readily be assessed.

Who carries out certain aspects of treatment may depend to some extent on cost considerations. Psychotherapy in budget-conscious public clinics is often not provided by psychiatrists, but by less highly paid non-medical therapists. Psychiatrists in primary care settings, therefore, must be prepared to justify their role whenever they themselves carry out the therapy.
CONCLUSION

The best interests of the public as well as of the profession require psychiatrists to seek out and to use every possible opportunity to help primary care physicians develop their diagnostic and therapeutic skills in mental health. The public will benefit from these efforts because more patients will be helped sooner, particularly those patients whose psychiatric disorders present with physical rather than mental symptoms. Psychiatrists can find opportunities to work with primary care physicians in medical schools and in training programs, through informal arrangements with physicians in private practice, and in integrated health care services.

Teaching and Training

In many American medical schools, extensive undergraduate and graduate programs in family practice and primary care have been established or are currently being established, almost all with a significant commitment to teach the psychosocial components of primary care. This is one important area in which psychiatrists may participate.

The possibilities for participation depend on the extent of the particular medical school's commitment to primary care, which in turn depends on a considerable extent on its overall philosophy and orientation. Psychiatrists who teach in medical schools which are a part of private universities may be less involved in primary care because their faculties do not have to be as responsive to public expectations and demands as those of medical schools supported primarily through public funds.

In the long run, however, all psychiatrists, even those who are not involved in teaching, need to be aware of the implications of current developments in primary care and their relationship to public attitudes. It was the impact of public expectations and demands that led in the 1970's to the federal government's policy of inducing medical schools to educate more primary care physicians by attaching such stipulations to the granting of capitation funds. At the same time, both federal and state governments seem equally concerned with curtailing the numbers of future specialists. Thus, in one state, rigid quotas for each residency program have been proposed.

Many psychiatrists are opposed to these developments, and prefer to continue in the patterns of teaching and practice that they have found so productive in the past. We do not believe, however, that the profession of psychiatry can stand aloof in the years ahead from the significant social changes that are reflected in these legislative attitudes and initiatives. Psychiatrists not only must be aware of these changes but must be prepared to participate actively and effectively in primary care education and systems of care.

In this report we have recommended, therefore, that psychiatrists adapt at least part of their teaching to the context of primary care. To do so effectively requires more emphasis on the normal, as well as on the pathological, than is traditional in clinical teaching. This extension in emphasis, in turn, requires us to learn and to teach more about human development, more about sociocultural values, and, most of all, more about family structure and functioning because of the family's primary role in human development, in health promotion, and in health care. This broader background can help us to share with primary care a genuinely holistic approach to people and how they function, or fail to function, and a biopsychosocial view of health and illness. One of the most significant contributions psychiatrists can make to the education of primary care physicians is in teaching a balanced approach to the interviewing of
Integrated Services

In this report we have described several ways in which mental health care has been integrated with primary care. We have reviewed three U.S. programs which have brought psychiatrists into close consultative contact with primary care physicians in traditional forms of private practice. Although these programs have apparently been successful in achieving their educational goals, they have not been emulated widely and they have not prospered without government subsidies. We believe that this interface between psychiatry and primary care is extremely important, and we strongly recommend that the public and private sectors should resume and intensify their collaboration in the development and evaluation of this type of project.

We have seen more progress in the collaboration of general medicine and psychiatry in primary care centers, in neighborhood health centers, and in prepaid health care programs. We believe that psychiatric services should not remain isolated as separate specialty clinics in these primary care programs, but instead should become fully integrated and should collaborate actively in the development and implementation of each program's overall educational, preventive, and therapeutic efforts. Psychiatric personnel can then work within the integrated primary care health service to devise effective linkages with backup public or private mental health systems for secondary and tertiary levels of care which cannot be provided within the primary care setting. Mental health components in primary care are important for all patients and their families. They are particularly important for patients with emotional problems who are not psychologically oriented or motivated to seek psychiatric care on their own but who are likely to be less hesitant in bringing their problems to the attention of their personal physicians and their collaborators.

Involvement in teamwork necessary to accomplish both teaching and service goals is not likely to be easy for the team members and will require constant effort and open lines of communication. Change is always difficult, and psychiatrists, along with other physicians, have been reluctant to adapt to new care patterns and to new quality controls, particularly since many of these changes have been "forced" on them by legislators, if not the public. We believe, however, that adaptation to these changes is good psychiatric practice and will result in an essential contribution to holistic care in the treatment of patients and their families.
Appendix

A few representative educational programs for medical students and residents will be briefly summarized here. These curricula will not be detailed in full because, although up-to-date as far as possible, changes occur annually. Therefore, the resource persons for each program are indicated. Details for other such curricula can also be found in a Resource Document (I and II) entitled TEACHING INTERPERSONAL SKILLS TO HEALTH PROFESSIONALS, edited by B. F. Cohen and T. W. Fivel (Amherst, MA: Carkhuff Associates, 1978).

The Summer Course in Family Practice, a pre-clinical program for medical students at the University of Virginia School of Medicine. (C. Knight Aldrich, M.D., Box 269, Medical Center, University of Virginia, Charlottesville, VA 22908).

The Virginia Summer Course in Family Practice is a nine-week full-time summer elective course in family practice offered at the University of Virginia to about 25 medical students who are scheduled to matriculate in the fall. It provides the earliest possible exposure to clinical teaching.

The course is coordinated by a psychiatrist and assisted by a part-time family physician. It consists of eight weeks of seminars, correlating sessions, experience in interviewing, and field work, followed by a full week's preceptorship when the student lives in a family physician's home and participates to the extent possible in all of the host's professional activities. The week's preceptorship is the culmination of the course.

The first eight weeks are oriented toward preparing the students to observe and understand human behavior in the context of medical practice. Since the students have yet to be exposed to basic science teaching, the emphasis is on the psychosocial aspects of family practice, which distinguishes family practice from other primary care specialties such as internal medicine, pediatrics, and obstetrics. Both emphasis and timing of the course, therefore, give the psychiatrist-coordinator a unique opportunity to show students how a basic understanding of human behavior is relevant and applicable to medical practice and to the work of the physician. The course includes five major themes presented in sequence:

- The Primary Care Physician and His Patients
- The Primary Care Physician and the Health Care Delivery System
- The Primary Care Physicians' Community Resources
- Community Agencies and the Primary Care Physician
- Prevention

The course extends over 82 hours and includes patient and family contacts in small groups.

The University of Washington School of Medicine. Introduction to Clinical Medicine—Human Biology, 513, is given in the first year.

This course is offered by the Department of Family Medicine under the direction of C. K. Smith, M.D., a psychiatrist, and is designed to help students develop comfort in the physician role, to acquire a sensitive and comprehensive approach to patient care, to learn interviewing skills, and to collect and record history and examination data. There are 16—18 hours per quarter (three months) and includes four interview sessions which are reported to tutors as well as one videotape session which is reviewed with the tutor.

In the clinical years, half of the class enters a Family Practice Track. A preceptorship in a rural practice is included in the fourth year for each student.

The first-year students also have an inter-departmental course on "the ages of man," presenting human development and the life cycle with emphasis on the medically significant phases, such as aging.
The Michigan State University School of Medicine has long emphasized the education of family physicians and interpersonal practice skills as part of the curriculum of students. (Ray Helfer, M.D., or J. M. Schneider, M.D., Michigan State University, East Lansing, MI 48823)

A method called Interpersonal Process Recall has been developed as the major tool for teaching interviewing and professional interaction. Simulated patients, including mothers, are used as interviewees and teachers. These exercises are conducted throughout the four years together with progressive didactic and clinical teaching about psychosocial issues of patients and their treatments.

The University of Minnesota Department of Family Practice and Community Health is responsible for both undergraduate and graduate education for Family Practice residents. (Donald Cassata, M.D., University of Minnesota, Department of Family Practice and Community Health, Minneapolis, MN)

This training model is based on a humanistic and holistic approach to medicine. Students and residents learn not only how to gather all needed information (psychosocial, physical, etc.), but also how to establish a trusting and open relationship with patients.

There is extensive use of videotechnology for recording interviews, conferences, examinations, etc. The program also involves an innovative rural-physician program through the use of porta-pak equipment. Students and residents tape an interview with a real patient, review the tape with a physician as well as a behavioral scientist, set goals for the next session, and receive a follow-up letter covering the points of the review session. Attention is paid to both content and process in the interview, and to both cognitive and affective phenomena shown by patients and student or resident.

The training is being expanded to increase rural practice opportunities and to overcome some of the logistic problems faced by all programs trying to teach interpersonal skills.

Temple University Family Practice Training in Psychiatry and Behavioral Sciences. (M. Simpson, M.D., Temple University School of Medicine, Philadelphia, PA)

This is an integrated residency program with the following objectives:

- Understanding the relevant technical terms, concepts, methods, and procedures applying to normal and abnormal human behavior arising from organic brain disease or functional disturbances of the mind;
- To know the indications and methods for obtaining a psychiatric consultation and for making a referral to a psychiatric facility for treatment; to understand generally the indications and contraindications for psychiatric hospitalization, for major psychiatric therapies such as intensive psychotherapy and electroconvulsive therapy; and be able to prepare a patient or a family for psychiatric consultation or referral;
- To develop and improve basic clinical interview skills with regard to all types of clinical consultations—psychiatric and non-psychiatric; with regard to establishing a constructive doctor-patient relationship, effectively gathering information from, and giving information to patients;
- To know the indications and contraindications for the use of psychotropic drugs; be competent in their use for managing typical emotional problems as seen in family practice and be able to use such drugs as required in a crisis or emergency situation; and be able to carry out continuing medication programs for patients discharged from psychiatric hospitalization or following a psychiatric consultation;
- To provide short-term and/or crisis psychiatric treatment for individuals and families within your setting, including both psychotherapy and pharmacology;
- To know the skills and services provided by other types of mental health professionals, the nature of services offered by
public and private agencies and institutions such as clinics, hospitals, social agencies, etc., and how to find, use and refer to them in order to meet the needs of patients;

- To manage one's sensitivity to, and understanding of, the emotional and psychosocial aspects of patients' problems, and understanding the contribution of emotional conflict toward the genesis of health problems and the impact of illness on the patient's emotional state and personality, as well as on the family;

- To understand and manage one's own emotional responses so as to minimize problems and conflicts with regard to the physician's personal life, his/her family and practice, as well as with other patients.

A series of "core" content lectures covering the basic psychiatric knowledge for regular practice and for the boards will be given; at least 15 mental status examinations must be completed and presented to preceptors; and, similarly, at least 15 routine clinical patient interviews and consultations will be observed and discussed by a preceptor or faculty member.

These activities will continue in the Family Practice Center; also, a two-months' psychiatry rotation at Temple University Hospital with the opportunity to attend rounds, seminars, and lectures on psychopathology, psychiatric therapies, and child psychiatry. Residents will join a psychiatric outpatient clinic team spending two half-days a week in the Crisis Center, will spend time on the consultation-liaison service working with faculty and psychiatric residents in assessing the psychosocial dysfunction and management of hospitalized patients with a wide variety of general medical and surgical problems, and also learn applied psychopharmacology.

A variety of electives are available. A work-group similar to those described in General Practice by Balint conducted by Dr. Simpson and a co-leader meets throughout the three years of the program.

**Psychiatry Teaching for Primary Care Physicians at the University of Vermont School of Medicine.** (Dr. Rollin M. Gallagher, University of Vermont, Waterman Bldg, Burlington, VT 05401)

In this program, PG-I residents work on psychiatric wards. In addition, they receive intensive interviewing instructions through videotape reviews. Child and adolescent psychiatry through a 12-module seminar, as well as courses in family assessment and treatment are also offered.

Other unusual features of this program include a weekly group exercise consisting of a case presentation and discussion of the group process, routine use of genograms for family evaluation, and a psychosocial profile for all patients. There is also a special program in primary care liaison work.

**Dartmouth Medical School Department of Psychiatry Fellowship Programs in Rural Community Psychiatry.** (R. J. Chapman, M.D., Director, Rural Community Psychiatry Fellowship Program, Hanover, NH 03755)

The purpose of this 6 or 12 month fellowship training program is to train rural practitioners of general psychiatry to sustain themselves, over time, in the rural community by achieving both professional and personal satisfaction. One of the major tasks of the program is to provide an opportunity for the trainee to develop effective strategies for working with other physicians and mental health professionals in the community.

The program selects psychiatric residents in their last year of training who show interest and promise and provides them with a community mental health center based clinical experience complemented by formal didactic seminars, clinical conferences, and individual supervision designed to help the trainee make a successful transition from academic medical training program to rural community practice.

The specific objectives of the Fellowship are:

- Exposure to psychiatric practice in the rural community setting;
Provide in the rural setting, at a distance from the medical center, opportunities for the trainee to assess his attitudes, increase his knowledge and develop his skills;

- Provide opportunities to explore the mix of clinical practice (public and private), administration including practice management, ongoing educational needs, as well as monetary and altruistic rewards necessary for professional satisfaction;

- Provide opportunities for each trainee to begin to explore along with his/her spouse the necessary mix of personal lifestyle and family needs to provide for personal satisfaction.

For the community mental health center, the program provides—

- A feasible model for the continual linkage between the community-based facilities and the academic center to further mutual growth and benefits;

- Intellectual and professional stimulation for professional staffs at community-based facilities;

- Evaluation of the impact of the trainees on the service delivery system, revenues generated, and overhead cost.

For the academic center—

- Develop a feasible model for continual linkage between the academic center and the community health facilities;

- To develop a syllabus of materials and experiences in book form for professionals who plan to work and teach in rural health organizations.

Program Description—The Fellowship Program focuses on: 1) Practical supervised/tutored clinical and non-clinical experience in rural community mental health center settings; and 2) Specific didactic seminars (often in a multidisciplinary setting with other professionals). The trainees live and work in either Rutland or Claremont, and spend one day a week in Hanover for the didactic and other supervisory and tutorial aspects of the program which includes a course in rural sociology.

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Chapter 4—Conclusion

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ACKNOWLEDGMENTS TO CONTRIBUTORS

The program of the Group for the Advancement of Psychiatry, a nonprofit, tax exempt organization, is made possible largely through the voluntary contributions and efforts of its members. For their financial assistance during the past fiscal year in helping it to fulfill its aims, GAP is grateful to the following:

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