Inspirational Recruitment and the Maryland Plan: Overcoming the Stigma of Public Psychiatry

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University-trained psychiatrists frequently avoid public-sector employment because they do not wish to be associated with stigmatized institutions. Inspirational recruitment—the elevation of poorly paid and unpleasant work to a noble cause—is one way of temporarily destigmatizing state psychiatry. The authors describe the impact of one such effort, the Maryland Plan, on recruitment of graduates of the University of Maryland psychiatric residency program into the state's psychiatric system. Significantly more graduates entered state psychiatry in the 15 years after the plan was implemented in 1978 (78 of 164 graduates, or 47.6 percent) than in the eight years before (seven of 57 graduates, or 12.3 percent). Data indicate that low salaries did not hurt recruitment, nor did doubling the stipends prevent the majority of recruits from leaving the public sector after a few years of service.

Almost two decades ago, the American psychiatric establishment placed the recruitment of university-trained psychiatrists into state service on its agenda. Yet psychiatric manpower problems continue to beset many states. As recently as 1991, representatives of chronic mentally ill patients indicted American psychiatry for allegedly ignoring the needs of their constituents (1).

It is therefore timely to report the impact on University of Maryland psychiatric residents of the Maryland Plan, a program designed to recruit university-trained psychiatrists into the public sector. Launched in 1976 as a joint initiative of the Maryland Mental Hygiene Administration and the University of Maryland's department of psychiatry, its purpose has been to "destigmatize" state psychiatry by recruiting large numbers of graduates of university psychiatric training programs into state service.

In order to make public psychiatry more attractive to university-trained recruits, changes in the working conditions of staff psychiatrists had to be effected (2). Mental hygiene administration leaders were convinced, however, that the required changes could be brought about only with the help of the new breed of psychiatrists they were trying to recruit. In order to attract university-trained psychiatrists, it was necessary to begin the process of destigmatization before, not after, basic changes in the state psychiatrists' job description had been made. But how could this change in perception be accomplished? The architects of the Maryland Plan decided on a strategy of "inspirational recruitment," a program designed to elevate unpleasant and poorly remunerated work to a noble cause.

A description of inspirational recruitment, the engine of the Maryland Plan, and its impact over 15 years on University of Maryland graduates' initial career decisions, is the focus of this report. We studied the outcomes by comparing the initial career choices of all University of Maryland psychiatric residents graduating between 1978 and 1992 with the choices of graduates during the eight years before the plan was implemented. Earlier papers have reported the steadily increasing numbers of university-trained psychiatrists recruited from all sources including the University of Maryland; the number is now well over 200 (3). Here we focus on recruits from our own department who chose state psychiatry immediately after graduation.

We shall try to answer the following questions: What motivated University of Maryland graduates to enter a highly stigmatized organization? How long did they remain in the public sector? What prompted those who left to make other career choices? Where did they go?

The Maryland Plan defined
In 1976 a group of recent graduates of the University of Maryland's psychiatric residency program assumed leadership of the Maryland Mental Hygiene Administration. They were committed to the rehabilitation of public psychiatry, which at that point was practiced mainly in three large, highly stigmatized state hospitals, nine smaller inpatient facilities, and a network of community mental health centers. The new leaders negotiated a comprehensive agreement with the university's department of psychiatry that comprised the following elements:

- Transfer of the Maryland Psychiatric Research Center from the mental hygiene administration to the department of psychiatry

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Abolition of autonomous residency training in the state hospitals
- Establishment of University of Maryland training units in the three large state hospitals
- University recruitment of psychiatrists for a new inner-city community mental health center adjacent to the medical school
- Six-month rotations in state treatment facilities for all university psychiatric residents
- Promotion of state psychiatrists according to ability rather than seniority
- Arrangement for state psychiatrists to teach university residents and medical students a half day a week on state time
- Understanding that decisions about education would be made by the university's department of psychiatry, and that decisions about service programs would be made by the Maryland Mental Hygiene Administration.

Seizing the high ground
The new state leaders inherited a dispirited, stigmatized organization employing large numbers of state-hospital-trained foreign medical graduates (FMGs). Approximately 70 percent of the staff psychiatrists and 100 percent of the psychiatric residents were foreign-born FMGs. Psychiatrists' salaries were among the lowest in the nation.

A strategy of inspirational recruitment was decided on to buy time to improve state psychiatrists' working conditions. To fire the imaginations of university graduates, the public sector was to be romanticized as the place to be, the place where the action was.

Maryland Plan leaders sounded a high moral note by announcing their intention to recruit the most capable graduates of Maryland's residency training programs for state programs. Access to university-trained psychiatrists was the right of the poor and the chronic mentally ill. A patriotic theme was introduced by naming the program the "Maryland Plan." Picked up and trumpeted by the Baltimore and Washington press (4,5), the Maryland Plan has won almost unanimous approval in professional and lay publications.

Recruitment strategies
Known since antiquity, the basic elements of inspirational recruitment were clearly stated in the New Testament letters of Paul of Tarsus. They include faith, future reward, fellowship, flexibility, and festivity.

Faith. Inspirational recruitment requires that the recruiter believe in his organization's mission. Representatives of public psychiatry are often burned-out administrators who no longer have confidence in what they are doing. What made the Maryland Plan leaders believe that they had more to offer university graduates than their predecessors? Part of their confidence was a result of youth and inexperience.

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Future reward. Maryland Plan recruiters were able to promise university-trained psychiatrists short-term and long-term benefits. As there were unfilled positions on all administrative levels, young graduates could be offered a variety of options. To make state psychiatry more attractive, the new leaders promised a streamlined bureaucracy, quick promotions, teaching opportunities, and resources for clinical projects.

Fellowship. Maryland Plan recruiters realized that the risk of entering a stigmatized organization could be lessened by having respected colleagues share that risk. Recruits were encouraged to undertake state assignments in pairs. In addition, university graduates tended to gravitate toward clinical services administered by psychiatrists who had taught them during residency training.

Flexibility. Having vacant positions to fill on all levels, Maryland Plan leaders were in an ideal position to match the needs of recruits with vacancies in the system. A central office administrator, who knew where all psychiatrist vacancies existed, coordinated recruitment throughout the state.

Festivity. Consumption of food and drink in a pleasant environment was a strategy from the start. Recruitment luncheons and annual banquets for senior residents in the Baltimore-Washington programs are two examples of this approach. Communal meals are powerful morale-building events; they are the core ritual experiences of many religious groups.

Survey methods
For this analysis, we considered 1978 the first year of the plan because the 1978 class was the first to be targeted by state recruiters. Our survey of pre-Maryland Plan graduates began
with 1970, the first year for which we have complete records.

The initial career choices of all University of Maryland residents graduating between July 1, 1970, and June 30, 1992, were obtained from records kept by the department of psychiatry’s residency training office, files maintained by the state mental hygiene administration, and telephone calls to graduates whose records were incomplete. Length of employment of those choosing state psychiatry was ascertained from the above sources.

Only those who worked half time to full time in the state system were counted as state recruits. Because recruitment efforts were directed primarily at residents in the adult psychiatry program, residents in child psychiatry and other subspecialties were not included in the survey if they did not complete at least two years of adult psychiatry in the university’s program.

Fifteen-year results
Between 1970 and 1977, the pre–Maryland Plan years, seven of 57 residents (12.3 percent) entered state psychiatry immediately after graduation. Between 1978 and 1992, a total of 78 of 164 graduates (47.6 percent) were recruited by the state ($\chi^2=20.78, df=1, p<.001$).

The state hospitals benefited most, acquiring 48 of the 78 recruits. During the eight pre–Maryland Plan years, only one of seven recruits chose hospital work. The three large, highly stigmatized state hospitals acquired 34 of the 48 state hospital recruits (70.8 percent). During the eight pre–Maryland Plan years, no graduates accepted positions in these three institutions.

**Men versus women recruits.** Between 1978 and 1992, a total of 36 of 90 men (40 percent) and 42 of 74 women (56.8 percent) entered state psychiatry ($\chi^2=3.92, df=1, p<.05$).

**Urban versus rural placements.** “Rural placements” refer to placements in facilities that were more than one hour’s driving time from Baltimore or Washington. Between 1978 and 1992, rural placements were chosen by eight of the 78 recruits (10.3 percent). During the eight pre–Maryland Plan years, no graduates chose rural psychiatry.

**American versus foreign medical graduates.** Of the 164 graduates between 1978 and 1992, a total of 135 (82.3 percent) were American medical graduates. American and foreign medical graduates entered state psychiatry in approximately equal numbers during the Maryland Plan years (46.7 percent of the recruits were American medical graduates, and 51.7 percent were FMGs).

**Quality of residents recruited.** Between 1978 and 1992, a total of 11 of 31 chief residents entered state psychiatry, compared with only one of 14 during the pre–Maryland Plan years. The plan also attracted eight of 16 winners of the coveted Brody Prize, awarded annually by the department of psychiatry since 1977 to the most gifted senior psychotherapist.

**Financial incentives.** Many states try to solve their psychiatrist recruitment problems by offering high salaries, bonuses, and attractive fringe benefits. Maryland Plan leaders have opposed such efforts when unaccompanied by improved working conditions. Figure 1 shows that the percentage of graduates choosing state psychiatry peaked in the late 1970s and early 1980s before entering stipends were appreciably raised. Indeed, during the most successful recruitment years, mental hygiene administration salaries were among the lowest in the nation.

**Retention**
Of the 78 graduates choosing state psychiatry between 1978 and 1992, a total of 35 (44.9 percent) were still employees of the Maryland Mental Hygiene Administration on June 30, 1992. The median length of employment for those who left was 3.5 years, and for those who remained, four years.

**Men versus women recruits.** Of the graduates who entered state psychiatry between 1978 and 1992, more women (N=25) than men (N=10) were retained by the state mental hygiene administration ($\chi^2=6.67, df=1, p<.01$).

**State hospital versus clinic placements.** Whether state recruits accepted inpatient or outpatient assignments influenced the likelihood of their remaining in the public sector. Thirteen of the 48 psychiatrists (27.1 percent) who began their careers in the state hospitals were still working for the state on June 30, 1992, compared with 16 of the 30 (53.3 percent) who started in clinics ($\chi^2=4.38, df=1, p<.05$). Only one of 24 male recruits (4.2 percent) to state hospital service was still doing hospital work in 1992, compared with 12 of 24 women graduates (50 percent; $\chi^2=10.55, df=1, p<.01$).

**Rural placements.** Only three of eight rural recruits were retained by...
the state. Four of the five who left state service remained in their distant locations but entered private practice.

Discussion

Why the recruits came, and why the majority left. Between July 1, 1978, and June 30, 1992, a total of 78 University of Maryland graduates were recruited into Maryland state psychiatry directly out of residency training. On the latter date, 35 were still working for the mental hygiene administration. Why did a majority of the recruits leave? Where did they go? First let us describe the apparent motives that brought them into the public sector in the first place.

A survey of 25 graduates recruited under the Maryland Plan (6) as well as impressions gained from many interviews with them allow us to categorize the recruits as follows.

Crusade leaders. The architects of the Maryland Plan on the state side, most members of this group were recruited from among the junior faculty of the University of Maryland. Some who were recruited directly out of residency training quickly became Maryland Plan leaders by virtue of their charisma and drive. Together with their university mentors, the crusade leaders conceived of and implemented the psychiatrist recruitment program as part of a grander scheme to rehabilitate public psychiatry in Maryland. Some of this group were true believers in state psychiatry: they were convinced that the incentives for treating the poor and neglected existed only in the public sector. Others were not converts to public psychiatry but were intoxicayed by the exercise of power. They wanted to "shake up the system" and make it more responsive to patients' needs.

Seekers of temporary jobs. After residency training, many graduates seek temporary salaried positions while building a private practice. State psychiatry provides many such opportunities, but before the Maryland Plan was implemented, few university graduates were willing to work in the stigmatized public sector. By destigmatizing public psychiatry through inspirational recruitment, Maryland Plan leaders recruited a number of temporary-job seekers.

Middle-level managers. Recruits in this group were drawn to the administration of inpatient and outpatient units. Lacking the ambition of crusaders who occupied the central-office and top hospital positions, they proved to be among the most stable of the graduates.

Sixties-style idealists. Recruits in this group were participants in or close observers of the student revolt of the 1960s. To a degree, they were indoctrinated into the counterculture of the sixties, although not to the point of abandoning conventional career choices. The Maryland Plan offered this group a chance to renew the struggle with authority.

Peace Corps types. Some graduates caught up in the Maryland Plan excitement wanted an "experience" in public psychiatry. Not planning careers in state psychiatry, they wished to participate, for a while, in an intoxicating social movement in the way that many white, Northern college students joined civil rights demonstrations in the 1960s, and other students enrolled in the Peace Corps.

University affiliates. Some recruits were attracted to the public sector because the strong state-university linkage afforded academic opportunities without requiring a full commitment to university discipline. These graduates enjoyed teaching medical students, supervising residents, and spending some of their time on the university campus.

The average recruit did not fit neatly into a single category. Most were motivated by multiple desires.

Reasons for leaving state psychiatry are closely tied to motives for entering the public sector. Crusade leaders left when their attempts to rehabilitate state psychiatry under medical leadership were thwarted by their Health Department superiors. Many 1960s-style idealists left with the crusade leaders to whom they were closely tied. Numerous temporary-job seekers and Peace Corps types resigned after a few years, just as they had planned to do. Mid-level managers and university affiliates were the most likely to stay on because they were able to realize their aspirations in the public sector. Some recruits remained because of collegial relationships and because, after ten years, future retirement benefits made continued state employment a practical option.

Many recruits who left state psychiatry have chosen careers in the private sector. Some crusaders have taken administrative positions in managed care organizations, for which their state experience provided excellent preparation.

Recruitment and retention lessons

Our data indicate that inspirational recruitment can destigmatize, at least for a while, recruitment of psychiatrists for state service. Figure 1 shows that 15 years after the launching of the Maryland Plan, University of Maryland graduates were still entering the public sector in respectable numbers—about 40 percent of the class—even though the original leaders were no longer directing the program.

Administrators who believe that money alone can solve state recruitment problems will note that the Maryland Plan was most successful in the years before entering salaries were substantially increased. Doubling stipends did not prevent many recruits from leaving state service.

Our retention data suggest that psychiatrists' working conditions were not sufficiently improved to satisfy many recruits. A majority of the graduates have left state employment; less than one-third of the male recruits remain. Greater retention success with women is probably due to the mental hygiene administration's allowing mothers to expand and contract working hours to accommodate changing family responsibilities.

Although it is too early to pass judgment on the Maryland Plan as a long-term recruitment model, certain observations are in order. Even when rigorously implemented, key program strategies worked against retention in ways not foreseen by the plan's architects. First, rapid promotion of university-trained psychiatry...
trists into central-office administrative positions left new recruits in the state hospitals inadequately supervised. Second, permission to teach at the University of Maryland on state time was not usually accompanied by reduced clinical responsibilities: state psychiatrists had to complete unfinished chores after regular working hours. Third, establishing a single training unit in each large state hospital led to competition among staff psychiatrists for residents. A class system developed, with the favored “academic” psychiatrists who supervised trainees being represented by those without trainees.

Were the above morale-eroding developments inevitable consequences of Maryland Plan structural flaws? Can they be corrected by administrative fine-tuning? The answers to these questions will be sought by the state and university leaders who are directing the Maryland Plan today.

References

Shifting the Responsibility for Payment for State Hospital Services to Community Mental Health Agencies

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Objective: In 1990 the state of Arkansas shifted financial responsibility for state hospital services to community mental health centers; through a policy known as “bed buy-back,” centers now authorize all state hospital admissions and prospectively purchase bed days for their patients. Characteristics of patients hospitalized before and after implementation of the policy were examined to determine how the policy affected hospital admission rates, types of patients admitted, and the amount of contact between CMHC and hospital staff about admitted patients, as well as how these elements were affected differently in rural and urban areas. Methods: Changes in the types of patients admitted over the 13 months before and 14 months after the change in financing were studied through retrospective chart review of 648 patients. Administrative data were used to examine changes in numbers of admissions for 30 months before and 26 months afterward. Data were analyzed by piecewise regression, least-squares, and logistic regression analyses. Results: After financial decentralization, state hospital use was reduced in both urban and rural areas, although the reduction in urban areas was proportionally greater. Contrary to expectation, admissions were not limited to the most severely ill, disruptive, or substance-abusing patients, nor were they more likely to be readmitted. For patients who were admitted, communication between the community and the state hospital was greater than before financial decentralization. Conclusions: Shifting financial responsibility for patient care significantly reduced state hospital use, did not affect patient mix, and apparently increased coordination of care between community and hospital. Whether bed buy-back has affected the kind or quality of services delivered in the community awaits further study.

One of the most important national trends in public mental health care has been the shifting of financial responsibility for patient care to local, community-based mental health agencies (1,2). A variety of motivations has initiated these changes, including the needs to reduce escalating mental health care costs, to integrate services for seriously mentally ill patients, and to allow more flexibility in service planning for individual clients.

However, the shift to community-based financial responsibility brings with it numerous potential