GOVERNMENT OF THE DISTRICT OF COLUMBIA
PUBLIC EMPLOYEE RELATIONS BOARD

In the Matter of: American Federation of State, County and Municipal Employees, District Council 20, AFL-CIO, Petitioner, and Commission on Mental Health Services, Department of Human Services, Respondent.	PERB Case No. 90-R-01 Opinion No. 278 (as amended 8/2/91)

AMENDED DECISION AND ORDER

On July 19, 1991, the District of Columbia Public Employee Relations Board (Board) issued a Decision and Order (Slip Op. 278) in the above-captioned proceeding. Subsequent to the issuance of the Board's decision finding appropriate a proposed unit of psychologists and ordering that an election be conducted, it was brought to the Board's attention that the Petitioner, the American Federation of State, County and Municipal Employees District 20 (AFSCME), had previously amended its Petition filed with the Board on December 22, 1989, and that said amendment was not acknowledged by the Board in its Opinion.

During the hearing session conducted on August 7, 1990, before a Board-designated hearing examiner, AFSCME's counsel stated on the record that AFSCME was amending the proposed unit description by deleting references to the inclusion of psychology interns and residents. Although AFSCME did not submit to the Board an amended Petition, there being no objection to the amendment, we accept AFSCME's on-the-record statement as a formal amendment to the Petition filed on December 22, 1989.

Accordingly, we amend our Opinion No. 278 to reflect the unit description as revised by AFSCME in its statement amending the Petition. [1]/

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[1]/ See Transcript Vol. 3, p. 352.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
PUBLIC EMPLOYEE RELATIONS BOARD

In the Matter of: American Federation of State, County and Municipal Employees, District Council 20, AFL-CIO, Petitioner, and Commission on Mental Health Services, Department of Human Services, Respondent.	PERB Case No. 90-R-01 Opinion No. 278

DECISION ON UNIT DETERMINATION
AND DIRECTION OF ELECTION

On December 22, 1989, the American Federation of State, County and Municipal Employees, District Council 20 (AFSCME) filed a Recognition Petition with the Public Employee Relations Board (Board). AFSCME seeks to represent, for purposes of collective bargaining, employees of the Commission on Mental Health Services (CMHS) in the following proposed unit:

> "All psychologists, clinical psychologists, psychology residents and psychology interns employed by the Commission of Mental Health Services excluding management officials, confidential employees, supervisors, any employee engaged in personnel work in other than a purely clerical capacity and any employee engaged in administration of the provisions of Title XVII of the District of Columbia Comprehensive Merit Personnel Act of 1978, D.C. Law 2-139." (Petition p.1)

The Petition was accompanied by a showing of interest meeting the requirements of Board (Interim) Rule 101.2. [1]/

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[1]/ The Interim Rules in effect at the time the Petition was filed have since been replaced by the Board's Final Rules effective August 10, 1990. The showing of interest requirement in Interim Rule 101.2, that proof be shown not more than one year old that at least thirty (30) per cent of the employees in the proposed unit

Notices concerning the Petition were posted on January 8, 1990. There were no requests to intervene in this proceeding. CMHS filed a Response to the Petition on January 17, 1990, asserting that the proposed unit did not constitute an appropriate unit for collective bargaining over terms and conditions of employment because (1) the proposed unit lacks the requisite community of interest; (2) the proposed unit would not promote effective labor relations and efficiency of agency operations; (3) the psychologists in the proposed unit share a community of interest with other CMHS professionals.

On February 13, 1990, AFSCME submitted a Reply disputing CMHS's assertions and offering counter arguments urging the Board to find that the unit, as proposed, is appropriate.

By Order dated March 20, 1990, the Board referred this matter to a Hearing Examiner duly designated by the Board to hear and take evidence on all issues relevant to the disposition of this Petition. The hearing took place on May 31, July 11, August 7 and September 27, 1990. Following the timely submission of post-hearing briefs, the Hearing Examiner issued a Report and Recommendation, a copy of which is annexed hereto, in which he concluded that the proposed unit was inappropriate and recommended that the Petition be dismissed.

Applying the criteria prescribed in D.C. Code Sec. 1-618.9 (a), which governs the establishment of terms-and-conditions bargaining units, the Hearing Examiner concluded that the essential ingredient, "community of interest", does not exist in the proposed unit of psychologists. Basing this conclusion on his finding that "the unit of psychologists do[es] not possess a separate and distinct community of interest because they are one of many disciplines functioning as an integrated member of the program....", the Hearing Examiner further concluded that the proposed unit would not promote effective labor relations as required by the Comprehensive Merit Personnel Act of 1978 (CMPA). (Report p. 22) He found, in this regard, that the psychologists' "working conditions, supervision, general functions in the organization, and their existence as an integral part of the treatment program are shared by numerous other unrepresented professionals." (Id.)

(footnote 1 Cont'd)
desire representation by the petitioner, is identical to the requirement set forth in the Board's Final Rule 502.2.

Although he acknowledged that the Board is not bound by National Labor Relations Board (NLRB) decisions or decisions of the Federal Labor Relations Authority (FLRA), the Hearing Examiner nevertheless suggested that the Board take cognizance of the NLRB's rule regarding hospital units, which does not provide for separate units of psychologists. The Hearing Examiner's Report also cites FLRA rulings in which the Authority has refused to find appropriate "separate units of members of an individual patient care component...where they are members of an integrated program." (Report at 24 citing Providence Veterans Administration Medical Center, 11 FLRA No. 44 (1983)).

AFSCME filed Exceptions to the Hearing Examiner's Report and Recommendation, arguing that (1) improper standards were applied to the community of interest criteria; (2) the Hearing Examiner ignored clearly proven and relevant factual evidence in his community of interest determination; (3) NLRB precedent is not applicable to the District labor relations law here and was improperly relied on by the Hearing Examiner; and (4) the Hearing Examiner "improperly interpret[ed] and applie[d] the 'effective labor relations' and 'efficiency of agency operations' criteria set forth in the CMPA." (Exceptions at 1-2) CMHS filed an Opposition to AFSCME's Exceptions urging dismissal of the Exceptions for failure to present a basis upon which the Report should be overturned or modified.

We have considered the record before us, including the Hearing Examiner's Report and Recommendation and the parties' pleadings. For the reasons that follow, the Board rejects the Hearing Examiner's recommendation that the petition be dismissed and finds appropriate the unit proposed by AFSCME in its Petition.

D.C. Code Sec. 1-605.2(1) authorizes the Board to "[r]esolve unit determination questions and other representation issues...[.]" Such determinations of an appropriate unit are to be made on a "case-to-case" basis and, in accordance with D.C. Code Sec. 1-618.9(a), "[n]o particular type of unit may be predetermined by management officials nor can there be any arbitrary limit upon the number of appropriate units within an agency." What then are the standards or criteria that the Board must consider in its establishment of an appropriate unit for collective bargaining over terms and conditions of employment? In D.C. Code Sec. 1-618.9(a), the CMPA stipulates that essential to every unit is a "community of interest" among the employees and an appropriate unit must be one "that promotes effective labor relations and efficiency of agency operations." Bearing these factors in mind, the Board concludes that although the Hearing Examiner carefully canvassed the record before him with respect

to the relevant criteria, i.e., shared interests, such as skills, supervision, and existence of integrated work processes, we find nothing in either statutory dictate Board precedent, or any compelling circumstance presented by the facts here that requires the Board to reject the proposed unit as inappropriate.

CMHS argues, and the Hearing Examiner agrees, that a proposed unit of psychologists does not possess a "separate and distinct" community of interest apart from other employees in a patient care group that includes, inter alia, social workers and mental health specialists. Therefore, according to the Hearing Examiner the establishment of such a unit would result in fragmented bargaining and impede effective labor-management relations. We are not persuaded that these concerns present valid objections to finding the proposed unit appropriate.

First, it is undisputed that there exists a community of interest among psychologists. The Hearing Examiner delineates the areas of shared conditions of employment among members of the proposed unit at pages 19-20 of his Report. There, he also enumerates the overlapping characteristics between psychologists and other health care professionals. CMHS contends that the latter finding supports the conclusion that a more appropriate unit would consist of psychologists and other unrepresented health care employees. However, we find no support for this contention in the pertinent statutory provisions. A finding of the requisite community of interest is not dependent upon whether a proposed unit of employees shares common working conditions "separate and distinct" from other employees. Moreover, there is no Board policy that a proposed working conditions unit must be rejected where a more appropriate unit could be created by including additional groups of employees. [2]/

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[2]/ There are significant differences between the provisions directing the determination of working conditions units in D.C. Code Section 1-618.9(a) and those that address the establishment of compensation units in D.C. Code Sec. 1-618.16(b). The former provision stipulates that working conditions units are to be determined on "the basis of a properly-supported request from a labor organization." (emphasis added) Conversely, the Board may determine compensation units sua sponte, in accordance with the latter provision 1-618.16, which states that such determination "shall not require a request from a labor organization." The Board construes its authority under the former provision to be limited to determining the appropriateness of a unit proposed by a labor organization that has demonstrated the required employee support. We are not authorized to require a "more" appropriate working conditions unit. Compare D.C. Code Sec. 1-618.9(c), which permits

Secondly, we find equally infirm the arguments that a unit consisting only of psychologists would impede effective labor relations and produce fragmented bargaining. CMHS cannot successfully defend its position that a separate unit of psychologists would be disruptive to labor relations when it has historically bargained with separate units of physicians and nurses -- employees whom the Hearing Examiner found also to be part of the patient care team and to share common working conditions with psychologists as well as other occupational groups comprising the treatment team.

In view of the foregoing discussion, the Board finds that the proposed unit meets the community of interest requirements, will promote effective labor relations and is appropriate for terms and conditions bargaining under D.C. Code Sec. 1-618.9(a).

The Board therefore directs that an election be held to determine the will of the eligible employees concerning representation in collective bargaining with CMHS.

ORDER

IT IS HEREBY ORDERED THAT:

The above-described unit is an appropriate unit for collective bargaining over terms and conditions of employment.

An election shall be held pursuant to Section 510 of the Rules of the Board to determine whether or not the unit employees wish to be represented by AFSCME District Council 20, for purposes of collective bargaining over compensation and other terms and conditions of employment.

BY ORDER OF THE PUBLIC EMPLOYEE RELATIONS BOARD
Washington, D.C.

July 19, 1991

(footnote 2 Cont'd)
the consolidation of working conditions units which upon a request by a labor organization with exclusive recognition and the Board's finding that the larger unit is appropriate.

ATTACHMENT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
PUBLIC EMPLOYEE RELATIONS BOARD

In the Matter of The Commission on Mental Health Services, Department of Human Services, Agency/Employer and American Federation of State, County, and Municipal Employees, District Council 20, AFL-CIO, Union/Petitioner	PERB Case No. 90-R-01 REPORT AND RECOMMENDATION

Appearances

For the Agency:
Mr. William D. Schucker and Sharon Paul, Esquire,
Office of Labor Relations and Collective Bargaining

For the Petitioner:
Kimberlee Keller, Esquire, of Kirschner, Weinberg & Dempsey

Hearing Examiner:
Louis Aronin, Esquire

The instant petition, seeking representation of a unit of psychologists employed by the Agency, was heard before the undersigned duly designated Hearing Examiner at Washington, D. C., on May 31, July 11, August 7, and September 27, 1990. All parties were given a full opportunity to present oral and documentary evidence, to examine and cross-examine witnesses, and to file briefs. Briefs have been received and have been considered.

Issue

Is a unit of psychologists and clinical psychologists, employed by the Commission on Mental Health, an appropriate unit within the meaning of Section 1-618-9 of the District of Columbia Code?

The Facts

The evidence reveals the following:

1. The Commission on Mental Health operates a hospital and residential institution to treat mental health patients (which was formerly operated by the U.S. Government as St. Elizabeth's

Hospital), an Emergency Psychiatric unit at D.C. General Hospital, and four regional clinics for treatment of patients on an out-patient basis.

The Commission operates through five components in which psychologists are employed--Office of the Chief Clinical Officer, Office of Mental Health Systems Development, Child and Youth Services Administration, Adult Services Administration and Forensic Services Administration.

The Clinical Officer, who is responsible for training and for establishing standards, has a branch for separate professional disciplines--Psychiatry, Psychology, Nursing, Social Work, Clinical Therapies, and "Group, Family and Organizational Consultation Branch."

The Office of Systems is involved in planning research and quality assurance.

The Child/Youth Services Administration, involving residential and non-residential services, operates through several regional out-patient components and three in-patient facilities.

The Adult Services Administration operates in-patient residential treatment centers at St. Elizabeth, an emergency psychiatric response division at D. C. General and four regional service centers.

The Forensic Services Administration performs services for the judicial system involving pre-trial and post-trial activities. That component also operates in conjunction with the penal system at Lorton and the jail. The Forensic Administration operates an in-patient service through eight (8) branches consisting of the substance abuse branch, pre-trial branch, post-trial branch, nursing branch, social service branch, psychology branch, medical branch and administration branch.

2. The largest component of the Agency is the Adult Service Administration which employees a total of 1,400-1,500 individuals. As noted, that component operates residential and out-patient clinics.

The professional employees include nurses, social workers, occupational therapists, psychiatrists, psychologists and dieticians.

The Agency also employs Mental Health Specialists, who are required to have a college degree with a major in health services or other sciences. The testimony indicates that the Mental Health Specialists are a carry over classification from the predecessor organization, St. Elizabeth. It was stated that the classification was a generic title in the "601 series."

3. Patients at emergency centers are interviewed by any available mental health professional who decides on future action.

A patient, considered for admission as an in-patient at a residential center, is interviewed by a nurse and is then more thoroughly interviewed by a nurse, a social worker, a psychiatric nurse, a psychologist and/or a mental health specialist. The particular specialists interview the patient to determine problems and unique characteristics regarding the patient and make assessments based on those interviews.

After each of the disciplines have obtained information, within a week to ten days after the initial entry of the patient, all disciplines participate in a treatment conference and plan a treatment program for the patient.

If the patient is hospitalized (institutionalized) more than thirty (30) days, a decision is made by the treatment group, consisting of the various disciplines, regarding transfer to the in-patient service branch of St. Elizabeth.

4. Patient treatment consists of individual therapy and/or group therapy of various types.

Treatment of the patient involves activities by members of the nursing staff, social workers, psychologists, psychiatrists, mental health specialists, and other mental health specialties.

Each patient's treatment is supervised by a mental health professional from any of the aforementioned disciplines who is a member of a team of mental health professionals.

5. The treatment is designed to assist the patient in adjusting to life outside the institution and involves occupational therapy, as well as psycho-social therapy.

When the patient leaves a residential program, the patient is assigned to a mental health center. At the out-patient center, the patient is assigned to a case manager, who may be a member of any of the mental health specialties--nurses, social workers, psychologists or mental health specialist.

6. One of the residential centers (Smith Center) treats patients with medical, as well as psychological problems. Generally, those patients are geriatric patients.

7. All of the mental health professionals from each of the disciplines are responsible for recordkeeping regarding patient care, including assessment, treatment and transfer of patients.

The nature of the records completed by each of the disciplines is determined by the Administrator of the particular program or programs.

The Agency policy regarding clinical recordkeeping, which is contained in the Agency Manual regarding recordkeeping provides, in pertinent part, as follows:

> 6. Documenting in the Clinical Record.
>
> a. The patient's record is the official and legal record of the patient's treatment and response to treatment. All authorized personnel (such as the physician, nursing staff, psychologist, social worker, occupational, art, recreation and dance therapists, dietitians, etc.) are responsible for documenting services which they provide during the patient's tenure on the rolls.
>
> . . .
>
> 11. Assessments.
>
> a. Each program in the Commission on Mental Health Services must determine the clinicians responsible for assessments and must assure that proper, sufficient, complete and timely assessments are documented in the patient's record.

The required assessments included a required physical examination, intake assessment, and the following specifics:

> (3) Emotional and behavioral assessment includes a history of previous emotional, behavioral, substance abuse problems and treatment, and the patients' current emotional and behavioral functioning. When indicated, a psychiatric evaluation; a mental status examination; psychological assessments including intellectual, projective, and personality testing; and other functional evaluations of language, self-care, and social-affective and visual-motor function are completed.
>
> Psychiatric Assessment. The psychiatrist or qualified psychologist will complete a psychiatric assessment and render a provisional diagnosis. An inventory of the patient's assets in descriptive, not interpretive fashion, is to be included.
>
> (4) Social Assessment which at least includes environment and home, religion, ethnic and cultural factors, family and childhood history, military service history, financial factors, social, peer-group, alcohol and drug abuse,

potential of family or significant others as a social support system, and the psycho-social level of functioning.

(5) Activities Assessment which includes hobbies, skills and use of free time. This assessment should include an estimate of the patient's abilities, limitations and degree of participation in structured individual or group activities.

(6) Nursing Assessment which includes an assessment of the needed nursing care. It should include cognitive and functional status, i.e., physical condition, ability to perform activities of daily living, and other nursing needs.

(7) In the in-patient residential, partial-hospitalization, and out-patient programs, vocational, nutritional, legal assessments and rehabilitation assessments are to be conducted when appropriate. The vocational assessment includes but is not limited to, vocational and educational histories and training. The legal assessment, includes, but is not limited to legal history and the urgency of the legal situation. The nutritional assessment includes at least, nutritional deficiencies, cultural/religious/ethnic preferences and special dietary requirements. The rehabilitation assessment includes rehabilitation potential functional maintenance needs; and the type, amount frequency and duration of treatment and procedures and modalities to be applied to physical, speech and occupational therapy needs. [underscoring in original]

. . .

13. Treatment Plan.

a. Purpose. Each patient shall have a written comprehensive, individualized treatment plan that is based on the documented assessments of the patients' clinical needs. Reflecting the program's philosophy of treatment, the treatment plan serves to describe and guide treatment, interventions. The treatment plan shall specifically indicate intervention methods, timetables, objectives and responsibilities. The treatment plan shall be developed in planning conferences with the appropriate disciplines and in collaboration with the patient, the patient's family (or significant others where such exist) and involved service providers.

b. Responsibilities. A case manager will be assigned to assure that multi-disciplinary treatment plans are developed and services are implemented and coordinated.

> In addition to the case manager, other staff may be assigned specific, direct service responsibilities consistent with the overall plan.
>
> In all in-patient and residential programs, the multi-disciplinary treatment plan must be signed by the psychiatrist, in addition to the clinician writing the plan.
>
> In out-patient programs, the multi-disciplinary treatment plan and up-date are to be signed by the psychiatrist or qualified psychologist, except when an up-date is completed by the case manager as outlined in Section 13.d.(3) below. [Underscoring in original.]

8. The record indicates that the "qualified psychologist" referenced in the Agency Manual is defined as a psychologist with "(1) Valid licensure to practice psychology in the District of Columbia; (2) One year of formal training in a hospital setting or two years of clinical experience in an organized health-care setting, one year of which is post-doctoral." (See Memo from Agency Commissioner dated September 1, 1988.)

9. The Agency policy regarding practices, procedures, responsibilities, and conduct of various disciplines, is set forth in CMHS Policy 50000, which, in pertinent part, provides:

> Medical Staff Organization Membership
>
> Section 1. Nature of Medical Staff Membership
>
> A. Membership in the Medical Staff Organization may be extended to all qualified health care professionals (physicians, psychologists, social workers, nurses, dentists, substance abuse counselors, pharmacists, and allied therapists (as defined in CMHS Policy 50000.122.1, Guidelines for the Assignment of Clinical Privileges for Medical Staff) who by reason of their application and satisfactory completion of D.C. Office of Personnel examinations were appointed to a position in the CMHS and are anticipated to engage in clinical practice without direct clinical supervision, in concert with their job descriptions and professional qualifications. Membership is also extended to all health care professional assigned to the CMHS by the Surgeon General, U.S. Public Health Service, and to consultants to the CMHS in concert with the above definitions.

. . .

The Executive Committee of the Medical Staff Organization is listed as:

(1) President (chair)
(2) Vice-President
(3) Chair Physician Practice Committee
(4) Physician Representative from the Adult Services Administration
(5) Physician Representative fro the Child and Youth Administration
(6) Physician Representative from the Forensic Services Administration
(7) Director of Psychology
(8) Director of Social Work
(9) Director for Nursing
(10) Coordinator, Allied Therapists
(11) Director, Quality Assurance Division (non-voting representative of the Commissioner)
(12) Member appointed by the Chief Clinical Officer (non-voting)

That Manual sets forth the responsibilities of the various disciplines, as follows:

Section 1. Physicians

Based on level of professional development, physician responsibilities may include:

(1) the performance of intake screening and assessment;
(2) the performance of psychiatric evaluations and diagnosis and mental health assessment of patient functioning;
(3) The provision of individual, group and family psychotherapy;
(4) the performance of case management services;
(5) the prescription and review of medication;
(6) the referral of patients to appropriate medical, surgical or subspecialty areas for physical medical needs and assurances of follow-up and completeness of medical care;
(7) the authorization of admission, change in status, transfer or discharge of patients;
(8) the performance of physical history, physical examinations, medical diagnosis, and the provision of primary medical care;
(9) the provision of consultation and participation in treatment planning;
(10) pre-service training and the training and supervision of professional staff;

(11) the performance of community consultation and education'
(12) the performance of clinical/administrative duties;
(13) the performance of various specialized psychiatric treatment procedures;
(14) dentists are responsible for the part of their patients' history and physical examination that relates to dentistry.
(15) Podiatrists are responsible for the part of their patients' history and physical examination that relates to podiatry.

Section 2. Psychologists

Based on level of professional development, clinical and counseling psychologists responsibilities may include:

(1) the performance of intake screening and assessments;
(2) the performance of mental health assessment of patient functioning;
(3) the provision of individual, group and family psychotherapy;
(4) the performance of case management;
(5) the performance of psychological assessments, employee standardized psychometric instruments;
(6) the provision of consultation and participation in treatment planning;
(7) pre-service training and the training and supervision of professional staff;
(8) the performance of community consultation and education;
(9) the performance of clinical/administrative duties;
(10) the performance of various specialized psychological activities; and
(11) the performance of research (and program evaluation) activities; and
(12) the performance of admission, management of care, transfer, and discharge of out-patients.
(13) the DSM-IIIR diagnosis of out-patients.

Section 3. Social Workers

Based on level of professional development, social worker responsibilities may include:

(1) the performance of intake screening and assessments, including psychological assessments;
(2) the provision of consultation to and participation in treatment planning;
(3) the provision of social casework with individuals, families and groups;

(4) the provision of individual, group and family psychotherapy;
(5) the provision of case management and outreach services.
(6) the provision of benefits acquisition and resource development.
(7) pre-service training and the training and supervision of professional staff;
(8) the performance of community consultations and education.
(9) the performance of clinical/administrative duties;
(10) the performance of quality assurance tasks;
(11) the performance of research activities.

Section 4. Registered Nurses

Based on level of preparation, registered nurse responsibilities may include:

(1) intake screening and assessments;
(2) mental health and health assessments;
(3) participation in treatment planning;
(4) provision in individual, group and family psychotherapy;
(5) case management services;
(6) administration of prescribed medications;
(7) health maintenance and health care teaching;
(8) psychiatric mental health nursing consultation;
(9) provision of pre-service training for nursing personnel;
(10) education and clinical supervision of professional staff;
(11) provision of nursing consultation and educational services to the community;
(12) management of nursing or clinical programs;
(13) administration of the delivery of nursing services to hospitalized patients.

Section 5. Allied Therapies

A. Allied Therapies include Art Therapy, Dance/Movement Therapy, Music Therapy, Vocational Assessment and Counseling, Vocational Rehabilitation, Therapeutic Recreation, Clinical Dietetics, Psychodrama, Chaplaincy, Speech Pathology; Audiology, Bibliotherapy, Occupational Therapy, Physical Therapy, and Educational Rehabilitation.

B. Based on area of disciplinary competence and level of development, responsibilities of Allied Therapists may include:

(1) assessment of client needs and problems;
(2) provision of clinical services/interventions appropriate to client needs;
(3) evaluation of services provided in light of the treatment objectives;
(4) collaboration with the multi-disciplinary treatment team in developing and implementing treatment plans and recording progress in meeting treatment objectives;
(5) pre-service training and training of professional and para-professional staff; and
(6) performance of clinical\administrative duties.

10. The D. C. Government regulations list requirements which are the same as those set forth above for a "qualified psychologist" and, additionally, provides:

> Section 21-501.1. Qualified Psychologists.
>
> (a) Qualified psychologists are subject to the restrictions and qualification for practice contained in the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D. C. Law 6-99; D.C. Code, see 2-3301.1 et seq.)
>
> (b) Whenever a qualified psychologist may have the responsibility for the voluntary, nonprotesting, emergency, or court-ordered hospitalization of mentally ill patient, that qualified psychologist or the hospital shall, prior or at the time of hospital admission, identify a psychiatrist or other appropriate physician with admitting privileges at the hospital who shall be responsible for the medical evaluation and medical management of the patient for the duration of the patient's hospitalization. The qualified psychologist shall be responsible for all other evaluation and management of the patient.

The same regulations at Section 21-521 provides that detention of a person believed to be mentally ill may be accomplished by "an accredited officer or agent of the Department of Human Services", an officer authorized to make arrests, or "a physician or qualified psychologist."

11. The District licensing regulations provide for licensing of certain health professionals, including registered nurses, occupational therapists, dieticians, social workers, and psychology, among others. A board of members of other various disciplines is established to regulate the health care specialty.

The specific provisions regarding the licensing of psychologists provides for a doctoral degree in psychology and 2

years of post-doctoral experience.

12. Licensing regulations, applicable to other disciplines involved in patient care, require that a clinical social worker shall have 3,00 hours of "post-masters or post-doctoral experience" involving diagnosis and treatment of individuals, families and groups with psycho-social problems.

Dance and recreation therapy practitioners are recognized but no specific requirements are established.

The regulations also list medical specialties and nurse requirements.

13. The several disciplines have their own directors. The director of the discipline establishes ethical standards for the specialty, a system of peer review of the specialists, and is involved in hiring decisions and professional directions. Directors exist for psychologists, social workers, psychiatrists, nurses, and recreational therapists. There is a Psychologist's Advisory Council which is involved in peer standards, training and quality assurance.

The employees are subject to direct supervision in their work setting by an administrator of the unit who may be a psychologist or a member of any other mental health specialty.

14. Record testimony indicates that psychologists are the only mental health professionals who administer tests to patients to determine motor skills and brain damage and who evaluate patients as an individual.

When such testing is performed by psychologist/interns, it is under supervisor of a licensed psychologist.

Psychologists generally treat the individual seeking behavior modification. The testimony indicates that, although other mental health professionals perform individual psychotherapy, they may be involved more frequently in social aspects, i.e., family and outside resources, in the case of the social worker or medical aspects in the case of nurses.

15. Psychologists, who are "qualified", were given authority and responsibility to admit patients to out-patient programs, to transfer them among centers, to direct a course of treatment and to discharge a patient from an out-patient program.

The memo authorizing these activities for "qualified psychologists", dated September 1, 1988, stated that the

qualifications required for those privileges were a "valid licensure to practice psychology in the District of Columbia" and one year of formal training in a hospital or two years of clinical experience.

16. Psychologists are members of an Association, the American Psychological Association, outside of work, which addresses the special concerns of psychologists involving privileges, regulations, ethical standards, training, credentials, and related matters.

17. Record testimony reveals that psychologists have daily interaction with other disciplines, but do not necessarily interact on a daily basis with other psychologists. The interaction with other mental health professionals occurs in the context of being members of a treatment team.

That treatment team includes all of the various disciplines--nurses, social workers, therapists of various types, mental health specialists, psychologists, psychiatrists, dieticians and nursing assistants. Assessments of all disciplines are considered in arriving at a treatment plan.

The team is directed by a Treatment Coordinator, who may be a member of any of the disciplines. The coordinator writes the treatment plan and oversees its implementation.

18. All unrepresented employees, who are professional employees, have common benefits and working conditions.

19. The evidence indicates that a psychologist may devote 5 hours to actually administering tests to a patient, involving interviews, and 10 hours to evaluation of the test results before preparing a report, or assessment and recommending treatment.

20. Testimony indicates that social workers, who do not administer psychological tests, do perform duties similar to that of the psychologists as regards patient assessment.

21. Psychologists are utilized by the court systems to evaluate defendants after administering tests.

The psychologists work in the Agency's pre-trial ward where defendants, who are placed there by the court, are evaluated as to competency to stand trial or evaluated for pre-sentencing purposes.

The psychologists testify in court reporting on the evaluation of the defendant and provide testimony as an expert witness.

The psychologists also evaluate individuals in conjunction with the propriety of their release from the mental institution to which they have been committed by a court. These evaluations are also made by psychiatrists.

Psychologists authorize the amount of liberty or privileges granted to patients, who are confined as the result of court action.

In many instances, the psychologist's evaluation is a recommendation, with final action being taken by the psychiatrist.

22. Record testimony indicates that a psychiatrist must approve all treatment and discharges, but that such approval is a "rubber stamp" approval of the recommendations of the psychologist.

It is also stated that psychologists perform the same duties as a psychiatrist except for prescribing medication.

23. The evidence reveals that psychologists are involved in individual therapy and group therapy.

Testimony reveals that some psychologists devote 25% of their time to admissions, including testing, and 75% of their time to therapy and others spend as much as 70% of their time testing and preparing reports and 20% in patient therapy.

24. The testimony differentiated the roles of the various specialists as follows:

The social worker report involves psycho-social assessment addressing the individual's relationship to his or her family.

The psychologist's report addresses a clinical view of the patient based on interviews and tests.

The multiple disciplinary reports are pulled together to develop a treatment plan, which was stated to be a team effort.

25. The Agency has recognized and does negotiate with a unit of physicians, including psychiatrists, and with a separate unit of nurses. There is also a unit of non-professional employees.

Testimony indicates that substantial time was required to negotiate the agreements for the non-professional unit.

It was stated by the Special Assistant that it would be inefficient to have a separate unit of psychologists.

26. The record indicates that there are no units in the D.C. Government limited to psychologists. It also indicates that the D.C. Government has psychologists in other departments, who are either not represented or are included in larger units of all employees or all professional employees.

27. The breakout of Career Service professional employees of the Agency, who are not represented in any bargaining unit, contains the following:

Career Service CMHS Bargaining Unit Eligible Professionals

Series		Appropriate No. of Employees
DS-101	Social Science Series	5
DS-180	Psychologist	60
DS-185	Social Worker	89
DS-510	Accountant	1
DS-601	Health Science	75
DS-630	Dietitian/Nutritionist	6
DS-631	Occupational Therapist	5
DS-637	Manual Arts Therapist	2
DS-638	Recreation Therapist/Creative Arts Therapist	32
DS-639	Education Therapist	2
DS-644	Medical Technologist	10
DS-660	Pharmacist	4
DS-665	Speech Pathologist/Audiologist	6
DS-688	Sanitarian	3
DS-807	General Engineer	1
DS-808	Architect	1
DS-810	Civil Engineer	1
DS-830	Mechanical Engineer	1
DS-1320	Chemist	1
DS-1530	Statistician	1
DS-1701	General Education and Training	6
DS-1710	Teacher/Education Specialist	7
DS-1715	Vocational Rehabilitation Specialist	7
DS-1728	Special Education Specialist	
	TOTAL	331

Pertinent Statutory Provisions

Section 1-618.9. Unit determination.

(a) The determination of an appropriate unit will be made on a case to case basis and will be made on the basis of a properly

supported request from a labor organization. No particular type of unit may be predetermined by management officials nor can there be any arbitrary limit upon the number of appropriate units within an agency. The essential ingredient in every unit is community of interest: Provided, however, that an appropriate unit must also be one that promotes effective labor relations and efficiency of agency operations. A unit should include individuals who share certain interests such as skills, working conditions, common supervision, physical location, organization structure, distinctiveness of functions performed and the existence of integrated work processes. No unit shall be established solely on the basis of the extent to which employees in a proposed unit have organized; however, membership in a labor organization may be considered as 1 factor in evaluating the community of interest of employees in a proposed unit.

Positions of the Parties

The Union contends that the unit of psychologists, which it seeks to represent, share a separate and distinct community of interest because only psychologists may test patients; they have substantial authority in treating patients; they diagnosis, and direct the course of treatment; they alone testify and provide assistance to the courts in criminal cases; they alone may sign treatment plans; and they have their own peer system for standards, privileges and quality assurance, including their own director, who is responsible for hiring psychologists.

The Union points to the psychologists educational requirements and internship requirements as establishing separate and unique common interests which distinguish them from other employees.

It points to the existence of a separate professional organization for psychologists.

The Union argues that the psychologists possess the common skills; common working conditions; common separate supervision in many instances; the same physical locations; a separate organization structure in the nature of a Director of Psychology; and are distinct from other employees because only the psychologists do testing and most of the psychotherapy.

The Union contends that, to the extent that other professionals perform functions similar to that of psychologists, the respective professionals bring their own specialization into play. It notes that, although all mental health professionals function as case managers, including the psychologists, the psychologists perform those duties a small percentage of their time.

The Union points to the psychologists common separate interest as evidenced by membership in a separate professional discipline,

separate licensing, a separate professional association, and separate peer review.

The Union argues that the Employer did not establish that the unit of psychologists would not promote effective labor relations or efficient agency operations.

The Union asserts that the absence of any other psychologist unit is attributable to the absence of any large group of psychologists outside of the instant Employer.

It asserts that the absence of any unit of psychologists does not constitute evidence that the unit sought is in any way improper. It argues 1-618.9 requires that the unit finding be on a case-by-case basis and that the possibility of a larger unit being preferable is not the issue because no such more inclusive unit has been proposed.

The Union argues that the unit will promote effective dealings and efficiency of agency operations because of the separate and unique skills, conditions, and interests of psychologists.

The Petitioner contends that case law does not require it to seek the most appropriate unit, citing NLRB cases. It points to PERB's decision in 84-0-07 finding a unit of dental hygienists as evidence to support a unit limited to a single discipline. It also notes the PERB certifications of units doctors and of nurses as support for a unit confined to a single discipline of psychologists. It asserts that psychologists, like other medical professionals, work together but have distinct interests. It compares the role of psychiatrists, covered in the doctor unit, as comparable to that of psychologists.

The Union argues that the NLRB criteria, in the health care industry, is not binding on PERB, noting that Congress mandated that the NLRB avoid proliferation of units--not a factor in the D.C. Code. The Union further asserts that the NLRB's eight unit structure is applicable to acute care hospitals and that the instant Employer only operates a small acute care hospital with most of its employees treating patients in different settings. It also contends that the NLRB has found units of separate medical specialties appropriate, citing a 1975 care involving dentists in a clinic setting.

The Employer asserts that the Employer functions along program lines and not individual professional lines so that psychologists and other professionals work within a program and receive direction and supervision from the assigned supervisor or director, who may or may not be a member of the same discipline. It notes all employees, including psychologists, report to managers and not discipline chiefs, who function as coordinators or consultants on issues unique to the specific disciplines, i.e., psychology or social work.

The Employer argues that psychologists are members of treatment teams with other professionals even if supervised by a member of their own specific discipline.

The Employer contends that, although some psychologists are authorized to admit or discharge patients, in out-patient programs, that authority does not exist in all programs. It notes the authority is delegated to qualified psychologists to admit and discharge in the out-patient programs.

The treatment team, per the Employer, is an interdisciplinary effort with representation from various disciplines, and works as a unified group. The team plans treatment as a collaborative effort and is lead by any of the disciplines who function as a coordinator.

The Employer contends that, although the psychologist performs certain duties that distinquish that profession from others, i.e., testing or court testimony, the other specialists also perform unique functions. It notes that, notwithstanding these differences, the various disciplines are functionally integrated as part of a patient treatment team.

The Employer points to each of the medical specialties having their own requirements for credentials, including education and experience.

The Employer argues commonality of rules, policies, and regulations exist for all professionals regardless of their specialty.

The Employer contends that the current four units that exist--(1) trades and crafts; (2) residual non-professional employees; (3) nurses, and (4) medical officers--are evidence of an effort by PERB to prevent a proliferation of units and represent, in some cases, a carry-over of units that existed before the establishment of the Commission.

It argues that 350 employees are currently unrepresented and consist of employees in 20 different occupational groups establishing the potential for a single or multiple unit. It notes the existence of three petitions, including the instant petition, as creating a potential for fragmentation and proliferation.

The Employer argues that the unit sought violates the Act where no such unit has been found in the past; where the Federal sector, which operates under a comparable law, has refused to find similar single professionals to be an appropriate unit.

It also points to NLRB decisions establishing seven units, none limited to a single discipline, other than nurses, and that the Board has never found a unit confined to psychologists to be appropriate.

The Employer argues that the Union has not established the existence of a separate and distinct community of interest or that a unit of psychologists will promote effective dealings and efficiency of operations. It notes the opposite as the result of excluding approximately 300 professional employees in 20 different career fields. It argues that a separate unit for each discipline would result in inefficient operations and prolonged negotiations.

It urges finding a broader unit of all unrepresented professional employees where they have common interests and conditions and where that broader unit would promote effective dealings and efficiency of agency operation.

Both parties cite numerous cases in support of their respective positions.

Discussion and Analysis

The statute mandates that there shall be no pre-determination of units and that the number of units within an agency shall not be based on "any arbitrary limit".

It does provide that the "essential ingredient in every unit is community of interest". It also requires that an appropriate unit must be one that "promotes effective labor relations and efficiency of agency operations". The statute then details the factors that affect community of interest--common skills, common conditions, common supervision, common physical location, the organizational structure, the "distinctiveness of functions performed and the existence of integrated work processes."

The unit criteria also indicates a unit shall not be based "solely on the basis of the extent to which employees in a proposed unit have organized."

This statutory provision is quite similar to that which has existed in Federal sector labor relations since 1969 under Executive Order 11491 and which is now codified as the Civil Service Reform Law of 1978.

The Federal labor management relations criteria for appropriate units added the requirement of promoting effective labor relations and efficiency of agency operations to community of interest, in 1969. The additional criteria first arose in New York State as a method of reducing the proliferation of units of recognition. It apparently first surfaced in the Taylor Act in 1967 when the New York State legislative added the two aforementioned criteria to the community of interest standard. The intent was to move the unit to the level at which effective bargaining could occur.

In a key case decided by the New York PERB it was faced with requests for representation of employees in 3700 classifications in 90 occupational groups. One petition sought to represent

physical therapists, another lawyers, a third nurses, a fourth rehabilitation counselors, a fifth employees in a psychiatric attendant series, and other separate groups of employees in each of numerous departments.

The New York PERB established five units, one of which included "Professional, Scientific and Technical Services" employees.

Various public jurisdictions since 1967 have mandated a specific number of units of recognition--Wisconsin, Hawaii, Alaska, Kansas, Pennsylvania, Maine, Vermont and others (see "Portrait of a Process-Collective Negotiations in Public Employment", edited by Robert Helsby, Labor Relations Press, 1979, p. 16-17; also see "Labor Relations in the Public Sector" Edwards, Clark and Craver, Bobbs-Merrill, 1979, p. 162-197).

Thus, the passage of the D.C. Merit System law in 1979 had, as background, the National Labor Relations Act and NLRB decisions which were based solely on community of interest and public sector laws which, in many instances, added the requirement that the unit promote effective dealings and promote efficiency of operation. It also had laws which delineated the specific units and those that, by direction or inference, sought to avoid a proliferation of units.

It is clear from this history that the statute wished to continue the virtually universal criteria of a community of interest and not predetermine the unit structure of the District. However, it is also clear that it wished to factor in the requirement that a unit promote effective labor relations and efficiency of agency operations.

With that background, it is appropriate that we consider the factors which favor the unit confined to psychologists of the Commission on Mental Health Services, as petitioned for.

The psychologists have a community of interest distinguishable from other professional employees based on the following:

(a) specific educational and experience requirements.

(b) licensure.

(c) a Director who is a member of their discipline who is involved in hiring of psychologists and advising the psychologists regarding their specialty.

(d) a system of privileges, study, accountability and quality control involving their peers.

(e) Their own association, which deals with professional problems of the discipline.

(f) They are the only mental health professionals who give psychological tests.

(g) Those psychologists, who are so designated, may admit and discharge patients in the out-patient programs.

(h) Psychologists testify in courts and prepare reports for courts; a function also performed by psychiatrists.

(i) They perform a substantial amount of the psychotherapy utilized in the various programs.

The psychologists have the following attributes and characteristics also found shared by other employees.

(a) All unrepresented employees, and many who are represented in collective bargaining units, are governed by the same personnel policies and practices and working conditions.

(b) Psychologists are one of the members of patient treatment teams consisting of social workers, mental health specialists, nurses, and other professionals.

(c) Each discipline provides a patient assessment, as does the psychologist, which is combined to determine treatment.

(d) Psychologists and other mental health professionals, i.e., social workers, nurses, mental health specialists, and others, work together to implement the treatment plan formulated for the patient.

All practice their specialties, including individual and group therapies, as well as involvement of family and community resources.

(e) The treatment team is lead by a coordinator who may be a member of any of the disciplines employed by the Agency, i.e., psychologist, nurse, social worker or other mental health professional.

(f) Each of the mental health professionals have specific educational requirements and licensing requirements set forth in the D. C. Code.

(g) There are Directors representing the specific disciplines, who establish credentials, privileges, peer review and quality control for the specific specialties.

(h) The various disciplines, including psychologists, work in the same geographic area when so assigned.

A balance of the characteristics, which establish a separate and distinct community of interest among psychologists and those

that do not provide that individuality, warrant a conclusion that they do not possess the community of interest viewed as essential for finding a unit appropriate, pursuant to 1-618.9.

The psychologists are, in reality, no more distinct than any other discipline involved in this proceeding. The social workers, the nurses, the dietitians, the therapists, and others each have their own educational requirements and own licensing process. Many disciplines have their own peer review, accreditation, quality control and professional organization.

Most critical is the fact that all, including the psychologists, are integrated into a program involved in evaluating the patient, determining a patient treatment plan and then implementing that treatment plan. That each discipline brings its own expertise and its own unique approach to treatment does not, in the view of the undersigned, create a separate and distinct community of interest for each discipline--more particularly, for the psychologists.

That the treatment team is led by any discipline is additional evidence of the integrated nature of the process. Thus, the psychologist may be the coordinator in team 1 and the nurse in team 2, etc. The psychologist is, based on the record, subject to supervision and direction in his or her work environment by same coordinator and/or manager who need not be a member of the same discipline.

The common working conditions, benefits, obligations, personnel policies and practices shared by all professionals is further evidence that the psychologists do not share a separate and distinct community of interest different than other unrepresented professionals.

We have carefully considered the psychologist's role in testing, admitting and discharging out-patients and in court reports and testimony. We do not find these special qualifications and special duties sufficient to outweigh the larger role where they function as an integral part of a whole system of patient care.

If the psychologist's unique qualification to administer psychological tests is determinative, then the 6 Dietitian/Nutritionists, the 5 Occupational Therapists, and 2 Manual Arts Therapists, etc., each have unique qualifications and each discipline may constitute a separate unit.

Based on the above, we conclude that the required "essential ingredient", referenced in 1-618.9, of a community of interest does not exist in the proposed unit of psychologists.

We deem it appropriate to also consider the additional requirement that the unit promote effective labor relations and efficiency of agency operations. These factors are evaluated for guidance of the Board if they disagree with the aforementioned conclusions.

In light of the finding that the unit of psychologists do not possess a separate and distinct community of interest because they are one of many disciplines functioning as an integrated member of the program, we cannot conclude that negotiations with this unit would promote effective labor relations. Since the psychologist's working conditions, supervision, general functions in the organization, and their existence as an integral part of the treatment program are shared by numerous other unrepresented professionals, negotiations with a representative of 60 psychologists, of a group of approximately 330 unrepresented professionals, would be the antithesis of effective labor relations. The interests and conditions of the psychologists, i.e., their separate community of interest, is not particularly different than that of the numerous professionals listed above who are also involved in the treatment of patients.

Because the psychologists do constitute an integral component of the Employer's program of treating patients, a separate unit of psychologists would result in fragmented bargaining and would not promote effective dealings.

For the same reasons, the efficiency of agency operations, another factor to be considered, would not be promoted if the Employer were required to negotiate with separate units representing the psychologists, as well as potentially each of the other disciplines involved in the program of patient care. Rather, a separate unit for each discipline would create a fragmented unit structure.

We have not been furnished any evidence that precedent exists to find that a unit limited to psychologists has been found appropriate.

By contrast, the NLRB has found the seven (7) units are appropriate in acute care hospitals (one of the instant Employer's facilities meets that criteria) with one unit grouping all professionals exclusive of registered nurses and of physicians.

Although the Board is not bound by NLRB decisions, particularly where the criteria is different regarding hospital units, it may take cognizance of those decisions. Thus, the acute hospital units do not provide for a separate unit of psychologists.

The NLRB decided not to include psychiatric institutions under the seven-unit approach noting, in part, in its proposed rule making notice that the following warranted a case-by-case approach:

> The evidence showed that unlike other acute care hospitals, psychiatric hospitals do not provide patient care for the physically ill. RNs are not the primary facilitators of health care in psychiatric hospitals. Many professionals participate hands-on with patients. Regardless of which of three basic models a psychiatric hospital follows: medical, milieu, or combined, the programs are highly integrated. RNs' work is closely integrated with the work of clinical psychologists, counselors, social workers, and various types of therapists in a treatment plan as designated by doctors and program coordinators.

Similarly, the discussion above also concludes that the program of the instant Employer consists of an integrated utilization of various disciplines.

A review of Federal sector cases, which are governed by unit criteria almost identical to that which guides the Board indicate the following:

In Providence Veterans Administration Medical Center, 11 FLRA No. 44 (1983), the Authority was faced with a request for a unit of professional employees excluding Title 38 professionals (as to whom statutory provisions control pay and appeal systems). The authority stated:

> The record establishes that the GS professionals here sought, as well as the Title 38 professional employees of the Activity, have the same or substantially similar occupational classifications and job descriptions and perform the same functions; work side-by-side as integrated medical treatment teams; have common supervision; are functionally integrated in carrying out the mission of the Activity; have essentially the same working conditions and are subject to the same legal and administrative constraints applicable to patient care. Moreover, as indicated above, there has been a history of collective bargaining at the Activity for a unit consisting of GS and Title 38 professional employees. While Title 38 professionals are paid under a slightly different salary scale than GS professionals and are in a different competitive area for purpose of reduction-in-force, the Authority concludes that such differences fail to support the Petitioner's assertion that Title 38 professional employees have a clear and identifiable community of interest separate and distinct from the other professional employees at the Activity. Accordingly, the Authority finds that the unit sought is not appropriate for exclusive recognition under section 7112(a)(1) of the Statute and shall therefore dismiss the petition.

In another case, 14 FLRA No. 28 (1984), where a unit of physicians was sought, the FLRA rejected the unit, noting in part,

> The Authority concludes that a physicians-only unit would not be appropriate in the instant case. A relatively small number

of physicians are involved, employed in various specialties. By the nature of their duties, which involve specialized work at a relatively small medical facility, they have as much contact with the other medical care professionals, as they have with each other. Like the other professionals, they are GS employees. As such, they are generally subject to the same personnel regulations and statutes affecting their personnel policies, practices and working conditions as are the other professionals. With the other professionals, they work regular hours during regularly scheduled workweeks.

The determination and administration of the physicians' working conditions and matters affecting their working conditions which are within the Activity's control are under the direction of management personnel who are not physicians. The same management personnel and the same management structure determine and administer the working conditions and matters affecting the working conditions of the other professionals. Complaints and grievances of the physicians regarding their working conditions are subject to administration and decision by management personnel who handle complaints and grievances of the other professionals. Although the physicians enjoy a great deal of independence and take initiative in the performance of their functions, by the nature of the Activity's facility and the small number of professionals involved, all of the professionals enjoy such independence. In practical effect, while all of the professionals are not equally involved with the physicians in the delivery of medical services, the professionals as a whole are engaged in a cooperative effort in furthering the Activity's mission for providing quality medical service and thus share a clear and identifiable community of interest.

Thus, the FLRA has refused to find separate units of members of an individual patient care component appropriate where they were members of an integrated program.

We now consider the Board's own decisions. The Petitioner points to the separate unit of physicians certified by PERB which exists at the instant Employer. That unit covers all physicians, including psychiatrists who perform functions similar to that of the psychologists. It does not separate dentists, physicians and podiatrists into their respective specialties, an approach sought in the instant Petition.

The Petitioner cites the Board's certification of a unit of Dental Hygienists 84-R-07 (1984) as evidence of a small unit confined to a single specialty. The record does not establish the rationale for that decision and we shall not seek to address that decision.

There is no evidence that any similar single specialty, other than registered nurses, has been recognized as an appropriate unit by PERB.