

ADMINISTRATION IN MENTAL HEALTH: ISSUES, PROBLEMS, AND PROSPECTS^{1, 2}

Saul Feldman, D.P.A.³

Rapid growth of the mental health field is demanding greater and greater administrative sophistication. In many cases, administrative knowledge and methods have simply not kept pace. This article helps to explain why this situation exists and how some of the current limitations can be overcome.

Introduction

The mental health field has grown very rapidly in recent years, both in size and complexity. Mental health programs are spending more money, employing more staff, serving more people in more varied ways, and providing services of greater scope than ever before. The traditional small outpatient clinic and the large baronial mental hospital are no longer the norm. While they have hardly disappeared, they may be approaching the organizational equivalent of endangered species. The mental health organization of the seventies is emerging as a complex, frequently decentralized system of services with diverse funding sources, multiple levels of accountability, and close ties with other human services. As a result, mental health administration has become very complex, demanding a high level of understanding and skill.

Unfortunately, this new complexity has not been matched by increased administrative sophistication. The potential of our advanced clinical knowledge and greater resources is all too often hampered by administration that was barely adequate in the horse and buggy days of mental health. In this sense, we are notorious underachievers and we fit well that famous phrase by Walt Kelly's Pogo—"We have met the enemy and they is us."

At the same time, the need to increase the effectiveness of administration in mental health is widely acknowledged. Indeed, it may be one of the few issues in the mental health field on which everyone agrees. Yet, progress has been slow, the difficulties seem to be expanding at a faster rate than our ability to deal with them, and we have a lot of catching up to do.

Special Problems of the Mental Health Field

There seem to be several factors contributing to our problems in mental health administration, and I would like to explore a few of these.

For one thing, mental health organizations are generally run by mental health professionals with little administrative knowledge or training. Lured by the prospect of higher salaries and status, they accept positions for which they have had little or no preparation. They tend to view administration as a rote, mechanistic process; as Levinson and Klerman (1967) have

¹Paper presented at the meeting of the Study Group on the Teaching of Mental Health in Schools of Public Health held in Caracas, Venezuela, on 23-27 June 1975; this activity was sponsored by the Pan American Health Organization in collaboration with the Ministry of Health and Social Welfare and the School of Public Health of Venezuela. Also appearing in Spanish in the *Boletín de la Oficina Sanitaria Panamericana*, 1975.

²For additional information on this subject, see page 270.

³Director, The Staff College, National Institute of Mental Health, U.S. Public Health Service, Department of Health, Education, and Welfare.

written (*I*), "Administrative work is usually regarded as categorically different from 'real' professional functions so basic to clinical work. It is typically associated with such terms as 'paperpushing,' 'mere detail,' and 'red tape' The main characteristics of the administrator are in the image of the anal character: neat, orderly, concerned with control, producing on schedule according to impersonal rules, and demanding production similarly from others."⁴

I do not mean to suggest that mental health professionals should be excluded from directing mental health programs in favor of others. In fact, I have become a bit impatient with the prolonged rhetoric and the journal articles debating this topic. Rather than a preoccupation with the professional identity of the administrator, the much more important issue is the nature of the training and experience required for success in mental health administration. In my opinion, understanding the substance of both mental health and of administration, as well as their interaction, is absolutely essential. Clinical programs are inseparable from administration—in effect, administration *is* program and program *is* administration. They coexist in a symbiotic relationship—it is an extremely rare clinical activity that does not affect administrative behavior and the reverse is equally true.

This essential unity between program and administration is often unrecognized. As a result, mental health professionals frequently confuse the role of administrator with that of the administrative specialist. The top administrator (executive, director) is both responsible and accountable for the entire program. This includes the organization's fiscal affairs, its internal management, the quality of its services, and its overall focus and direction. Ideally, he or she blends a knowledge of administration and of program substance and is sensitive to the reciprocal relationships between the two.

The administrative specialist, on the other hand, concentrates on one or more aspects of

the management process, such as budgeting or personnel. Like his clinical counterpart, who is primarily engaged in providing treatment and diagnostic services, his area of expertise is circumscribed. This does not minimize the importance of the administrative specialist in a mental health program. But these management processes are only one component of administration and are by no means synonymous with the entire administrative function.

Another obstacle to the improvement of administration in mental health is the too infrequent recognition that administration is substantially modified by the nature of the field in which it is applied. I know that some of my colleagues will consider this a heresy, but I am coming to feel that the term "administration" has relatively little in the way of generic content. While sharing a common base, administration in mental health differs from health administration and other similar fields because the substance of mental health is different—it has distinct characteristics that substantially modify the nature of the administrative task in mental health organizations. Some of these characteristics are as follows:

First, mental health services are dependent upon public funding and are frequently subject to a high degree of governmental regulation. Administrators of these services must therefore understand the political process and be able to work closely with government at all levels. While the degree of involvement varies between political jurisdictions, both the constraints and opportunities inherent in close ties to government are omnipresent in mental health administration.

Second, the typical staff in a mental health organization is multidisciplinary, professional, and highly autonomous—a bit like a Navy with more admirals than ships. Disciplinary rivalries, conflicts revolving around status and salary differences, and a professional identity that is inversely related to organizational loyalty add to the mental health administrator's task. In a study of 120 community mental health centers for example, Jones, *et al.* (1974) concluded that the staff members viewed the policies of

⁴Reference (*I*), p. 54.

these centers as subordinate to their own professional standards (2). In the event of a real or imagined conflict between the two, their allegiance would be with the standards.

Third, the transaction between the therapist and the patient is highly private and intimate in mental health—much more so than in most other fields. As a result, it is very difficult for the organization to collaborate with or intrude in the process, even when warranted. It is not unusual for the patient and therapist to enter into an alliance, not always conscious, in which the organization is viewed as the enemy, particularly regarding such unpleasantries as fee charging and decisions to terminate treatment.

Fourth, in mental health we are frequently dealing with a highly dependent patient population. This presents extraordinary problems for the administrator and staff in attempting to maintain a responsive, accountable, and humane program. The recurrent public scandals in some of our state mental hospitals and institutions for the retarded are unhappy reminders of this fact.

Fifth, in mental health our product is intangible and our degree of success is very difficult to determine and measure. The terrain is littered with ill-conceived and poorly executed evaluation studies, and the technology of mental health evaluation remains quite limited. It is, therefore, very difficult for the mental health administrator to evaluate the effectiveness of the organization, or even of individual staff members. These difficulties also exist for outside groups and organizations attempting to evaluate the utility of mental health programs. As a result, I suspect that at least some of the programs survive, and even grow, long after they have stopped benefiting anyone.

Sixth, the boundaries of mental health services are very difficult to define, as illustrated by the now too-familiar debate between advocates of the "medical" and "social" models of community mental health. While this ambivalence about boundaries and objectives has some obvious advantages, particularly for the administrator who wishes to avoid account-

ability, it permits the mental health organization to be seen as the vehicle for meeting a wide variety of frequently divergent needs and encourages unreal expectations. It is the discrepancy between these expectations and the actual services provided that have prompted some of the well-publicized conflicts in our community mental health programs.

Seventh, the poor public image of mental health services, the enduring stigma associated with their use, and the problems posed by confidentiality add significant complications to the administrative task in the mental health field.

And last, somewhat less tangible, but perhaps most important, is the need for a mental health organization to communicate hope and confidence to the people using its services. As Whittington (1973) has written (3), "While a surgeon may perform an operation with high technical competence even though he feels that the leader of his program is autocratic, arbitrary, and derogates his importance, the mental health practitioner can rarely function with optimal efficiency if he has similar feelings about the leader. In every transaction with a patient, the management of a mental health center is an invisible but by no means silent partner."⁵

This may be the most difficult challenge of all for mental health administrators—understanding the need to create and maintain an organizational climate of efficacy and hope. It is for this reason that I look forward to the time when all mental health administrators are required to spend some time as consumers of mental health services, as clients or patients if you will. I believe that the quality of our mental health and other human service programs in this country would improve substantially if administrators, both during their training and periodically thereafter, could view these services from the other side of the fence. We are all captives of the contexts within which we work, and this is a captivity for which our clients pay dearly.

⁵Reference (3), p. 58.

Academic Needs

Taken individually, the characteristics I have described obviously have their counterparts in other fields; but taken as a group, they separate mental health from the other human services, even ones that are closely related. To be effective, therefore, academic programs in mental health administration must reflect these characteristics through the development of specialized curricula and training procedures. Superficial rereading of existing curricula—for example, the addition of a course on “Principles of Mental Health” to a health administration program—is simply not sufficient to meet the needs of a growing and dynamic field.

And we badly need to increase our research in mental health administration. While we may be able to identify the particular characteristics and ethos of the mental health organization, we do not really understand how these affect the administrative task. Important research questions abound, and mental health executives should no longer be solely dependent upon their intuition (highly developed as it may be) and their experience to handle complex administrative problems.

To further complicate the teaching picture, administration is shaped not only by the nature of the particular field in which it is applied, but also by the needs and values of the parties to the process. Administration is therefore situational, and there are few, if any, principles in the sense of immutable truths that are transferable without modification between settings. Like proverbs, one principle conflicts with another and they are much better used to justify actions already taken than to help with decisions yet to be made. In fact, the best titled book on administration that I have ever seen is called *It All Depends*.

In my judgment, the good teaching program in mental health administration helps students understand what it all depends *on*—it helps them to identify and assess those important variables in any particular situation that must be considered in the decision-making process. And perhaps even more importantly, it teaches

them that uncertainty is omnipresent in the administrative task, that truth is elusive, and that the capacity to tolerate ambiguity and a lack of closure is essential to success in mental health administration. It has always seemed to me that in this sense mental health professionals are admirably equipped for the task.

It follows, therefore, that my approach to teaching administration is heavily oriented toward the real-life situations in which administrators work and the real-life problems with which they must cope. For the teaching of mental health administration, this approach requires curricula that reflect the major issues and problems encountered in the actual operation of mental health organizations and a faculty with expertise both in administration and in the field of mental health. It also requires a literature—journal articles, books, case studies, and research reports—relating specifically enough to the mental health field so that a good supply of current teaching material is always available. Literature dealing with business administration, public administration, or other such fields is simply not adequate.

Teaching mental health administration this way requires a much broader understanding of what mental health administrators do now and will be doing tomorrow. But without this understanding our teaching programs will almost certainly qualify for Einstein’s definition of education as “that which remains when one has forgotten everything he’s learned in school.”

Current and Future Trends

The real world of mental health services in which our future mental health executives will be working seems to be moving in the following directions:

First, our mental health services are broadening considerably, in both the range and scope of the services provided. Community mental health centers (CMHC’s), mental hospitals, and outpatient psychiatric clinics are diversifying their services more and more and expanding far beyond their traditional borders. The mix of

services is changing too. Now there is much heavier reliance than before upon outpatient care and other alternatives to hospitalization. And, of course, the rapid deinstitutionalization, particularly during the past decade, has led to increasing interest in the development of halfway houses and other structured living arrangements for former state hospital patients.

Increased resources are needed to make these programs of greater scope and complexity work. The average federally funded CMHC, for example, now has an annual budget of well over \$1,000,000, and at least 30 per cent of the centers spend more than that. Funding has also become much more diversified than in the past. Mental health programs often receive funds from as many as 10 sources with different reporting requirements and fiscal years. National health insurance, when it comes, will shift the balance somewhat, but is not likely to reduce the diversity.

The staffing patterns of our mental health programs reflect this greater size and diversity. These staffs are far more ecumenical than those of the past. Many programs employ people representing as many as 16 different occupations or professional disciplines. This heterogeneity, coupled with deemphasis of traditional credentials, makes the pattern differ markedly from earlier ones. I have referred before to the problems involved in managing mental health professionals. These are compounded by the addition of new personnel types—such as the indigenous nonprofessional—and by the role blurring, if not the salary blurring, that results.

To limit the adverse effects so often associated with organizational growth, mental health agencies are increasingly reorganizing and decentralizing their programs. This decentralization may take several forms, but two are most common: (1) the development of the now-familiar satellites in the community, and (2) the organization of staff members into geographic teams, with all teams operating from a central base but having their own territory and clientele. Whatever the specific mechanism, decentralization is intended to help ensure that mental health services do not become organiza-

tionally muscle-bound but, rather, remain accessible to the people they serve.

Of course, reorganization is a time-honored approach to all problems great and small, and in recent years its practice has been raised to the level of an art. It can give the appearance of change while, in fact, maintaining the *status quo*. It is something of a paradox that our most rigid inflexible organizations are those that seem always to be reorganizing. That this is not a recent phenomenon is indicated by the following: "We trained hard but it seemed that every time we were beginning to form up into teams, we would be reorganized. I learned later in life that we tend to meet any new situation by reorganization, and what a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency, and demoralization." (Petronius Arbiter, 210 B.C.)

Mental health service programs are much more heavily involved with sophisticated management technology than ever before, and mental health professionals now speak freely (but too often unwisely) about IBM "360-40's," "optical scanning," and "magnetic discs." A few short years ago these things were far beyond our horizons. The application of computers and other instruments to the mental health field seems to be growing rapidly, and we may be at (or over) the brink of a total commitment to magnetic tape, punchcards, programmers, and printouts.

While the value of good management information systems in mental health has become widely accepted, the problems and side-effects associated with them are less apparent and have been much less discussed. These include a greater potential for violations of confidentiality and the reification of diagnostic nomenclature as a convenient and uniform but too often misleading language with which to categorize patients. It is very clear that computers have great potential in the mental health field. But we should be ever mindful of the words by that great philosopher Charlie Brown, who said "There's no heavier burden than a great potential."

Another important development in mental health services is the emphasis on continuity of care—the easy movement of patients between services according to their needs. For example, over 40 per cent of all the federally funded CMHC's are composed of several different organizations working together by written agreement. This is an attempt to coordinate services and reduce the number of patients who "fall through the cracks" between the agencies from which they seek help.

But the barriers to such coordination are formidable. Parochial admission requirements, sanctimonious traditions, and a general organizational paranoia make continuity extremely difficult. It is very clear that while everyone is in favor of coordination, nobody really wants to be coordinated.

And as if we did not have enough problems with coordinating our own programs, mental health services are now expected to work much more closely with other health and human services. The organization of "umbrella" human service agencies in 36 of our states is one indication of this trend. As a result, directors of mental health programs are spending much more time at the boundaries between their organizations and others, practicing what might be called "foreign relations." Unfortunately, those of us in government and academia have not helped them very much. Our rhetoric has far outrun our ability to bring complex organizations together while preserving the best of their individuality; for in fact we know little about interorganizational relationships—a very important but much-neglected field of knowledge. By and large, this subject appears neglected or even absent in the curricula and research interests of our academic programs of health and mental health administration.

Finally, the age of accountability seems nearly upon us in mental health, and this accountability may be quite different from anything we have experienced in the past. It seems to have two major features: (1) A legal and/or moral responsibility to do something for which one must answer to someone else, and (2) A system for imposing a penalty in the

event of default or noncompliance. The effectiveness of any accountability system depends in good measure upon the availability and willingness to use penalties, such as the withholding of funds. While we have already developed some accountability mechanisms in mental health, they do not often include financial sanctions against improper practice.

The advent of the Professional Standards Review Organization (PSRO), a body with the power to review services and make recommendations to withhold medicaid and medicare funds, may change all that. At the present time, the PSRO's review function is limited to inpatient care, but if it works successfully its domain will likely be extended to outpatient services as well. It may also play a central role in the funding provided in connection with national health insurance.

It is obviously too early to tell whether the PSRO or some other yet-to-be-enunciated device will work as intended—as accountability with teeth. But if it does, it will be a major factor in the administration of mental health services.

These, then, are some of the major features that I believe will characterize mental health service programs in the next decade. Obviously, other projections are possible and perhaps preferable. Whatever the specifics, it is the shape and substance of mental health services that determines the nature of the administrator's job and, hopefully, the content of academic programs in mental health administration. In this connection, several new programs have begun in the past year or so, with others in the planning stage. They seem to be developing in a variety of different settings—in schools of public health, departments of health and hospital administration, schools of social work, schools of management and business administration, programs of public administration, and departments of psychiatry. It is probably too early to tell which of these environments is most salubrious—they may all be equally so.

For the future, it would be desirable to see several universities develop departments or schools of human services administration, at

least on a pilot basis. It is a rather sad commentary on the values of society that schools of business administration abound in my country, but their counterparts in the human services are difficult to find—despite the fact that the human services are consuming an ever-increasing share of our national resources.

The guiding values of the human services field and the organizations that compose it differ significantly from those found in the field of business. Therefore, the teaching of human services administration requires a curriculum tailored to the needs of the field and a faculty conversant with those needs. Such a curriculum could include a cluster of courses applicable to all the human services, as well as courses offering opportunities for specialization in such fields as health, mental health, social services, corrections, education, vocational rehabilitation, and others. These areas of specialization, now scattered throughout academia, would thus be brought together in a setting that enhances their interrelatedness and respects their individuality.

Conclusions

Whatever shape the new programs in mental health administration take, it is clear that a long period of neglect seems to be over. The efforts to promote mental health administration are finally beginning to work and will continue to do so.

Several happenings add to my optimism about the future well-being of education in mental health administration:

For one thing, a bill now before the Congress to renew the CMHC's Act authorizes spending up to 2 per cent of the annual appropriation for purposes of technical assistance and training in administration. At present funding levels, this could mean a federal expenditure of up to \$2,000,000 per annum. Even more important, it shows recognition by the Congress of the need for better mental health administration and a willingness to do something about it.

For another, the American Psychological

Association's Conference on Professional Training recently recommended that psychologists be trained in administration. This is an important recommendation, because of all the mental health professionals, psychologists have been the least inclined toward administration, either by training or by career patterns.

Furthermore, there is now a small but growing literature and several new doctoral dissertations in the field of mental health administration. The response to our journal, *Administration in Mental Health*, has been very enthusiastic, and we are now receiving a steadily increasing number of high-quality manuscripts to consider for publication. This is a good sign, since the volume and quality of the writing in a field are often a significant indicator of its development.

In addition, a National Task Force has been convened to study and recommend future directions for educational programs in mental health administration.

And finally, I no longer feel like a whore in a monastery when I preach the gospel of mental health administration in the otherwise pristine environments of psychology and psychiatry departments and at schools of social work. It appears that mental health professionals are feeling an increasingly strong need for expertise in administration. The executive role is apparently becoming much more ego syntonic for them. And there is a growing awareness that the abdication of administrative responsibility to those with a lesser commitment to the values of the mental health field may lead to the triumph of process over purpose. This is an all-too-frequent phenomenon in our society, and one that could severely retard the vitality and potential of mental health programs if left unchecked.

Malcolm Muggerridge has said: "I have always been deeply interested in the administrative side of love, which I find more absorbing than its purely erotic aspects. What Lady Chatterly and her gamekeeper did in the woods is, to me, of only passing interest, compared with how they got there, what arrangements were made for a shelter in case of inclement

weather and for refreshments, how they accounted for their absence, whether either party could recover incidental expenses, and if so, how. This attitude is, after all, not so unreasonable. Most great generals have admitted planning campaigns and winning victories in the field is relatively easy compared with arranging transport and supplies. 'An Army' Napoleon said, in one of his most celebrated remarks, 'marches on its stomach.' So do lovers. If the administrative arrangements are faulty, the campaign that follows cannot but be

laborious, and even victory brings little satisfaction."

While I must confess to a much greater interest than Mr. Muggerridge in what the good lady and the gamekeeper did in the woods, I think his point is well taken. To stretch the analogy somewhat, I would like to encourage a much greater intimacy between mental health and administration. While I can't promise that this love affair will be as erotic or exciting as Lady Chatterly's, I know it will be rewarding.

SUMMARY

The mental health field has grown larger and more complex in recent years, but this has not been equalled by increased administrative sophistication. Two problems, neither one irremediable, have contributed to this state of affairs. First, mental health organizations have generally been administered by mental health professionals with little administrative knowledge or training. And second, we have often failed to recognize the very special circumstances faced by administrators in the mental health field.

These special circumstances are legion. For one thing, mental health services depend on public funding and must often deal with a high degree of government regulation. For another, the typical staff in a mental health organization is multidisciplinary, professional, and highly autonomous—a bit like a Navy with more admirals than ships. Then too, the transaction between therapist and patient is much more private and intimate in mental health than in most other fields; we are often dealing with a highly dependent patient population; our product is intangible and the success achieved is hard to judge; the boundaries of the field are very hard to define; and the enduring public stigma associated with use of mental health services, combined with the problem of confidentiality, complicates the administrative task. Finally, on top of all this, it is absolutely essential that the mental health administrator understand the need to create and maintain an organizational climate of efficacy and hope.

Taken individually, many of these conditions have obvious counterparts in other fields; but taken as a group, they separate mental health from all the other human services, even ones that are closely related. To be effective,

therefore, academic programs in mental health administration must reflect these conditions by developing specialized curricula and training procedures.

Such programs would also benefit from a strong orientation toward the real-life situations and problems faced by mental health administrators. Instruction of this kind requires a much broader understanding of what mental health administrators do now and will be doing tomorrow. But without this understanding our teaching programs will almost certainly qualify for Einstein's definition of education as "that which remains when one has forgotten everything he learned in school."

Right now, mental health services seem to be moving in the following directions: There is a considerable broadening in the scope and range of services provided and in the size and diversity of staffs. To limit the adverse effects so often associated with organizational growth, health agencies are increasingly reorganizing and decentralizing their programs. In addition, mental health programs have become heavily involved with sophisticated management technology; it is now very clear that computers have a great potential in mental health, though whether they will live up to their advance billing is hard to tell. Other important developments are the new emphasis on continuity of mental health care and the fact that mental health services are now expected to work much more closely with other health and human services.

In addition, the age of accountability seems nearly upon us, in terms of both a legal and moral responsibility to be answerable and emergence of a system for imposing penalties in the event of default or noncompliance. It is much

too early to tell whether any arrangement now envisaged will eventually create such an accountability with teeth; but if it does, this

too will become a major factor in mental health services administration.

REFERENCES

- (1) Levinson, D., and G. Klerman. The clinician-executive. *Administration in Mental Health*, Winter, 1972, pp. 52-67.
- (2) Jones, J. D., S. S. Robin, and M. O. Wagenfeld. Rural mental health centers: Are they different? *International Journal of Mental Health* 3 (2-3): 77-92, 1974.
- (3) Wittington, H. G. Personnel management: People make programs. In: Feldman, S. (ed.), *The Administration of Mental Health Services*. Charles C. Thomas, Springfield, Illinois, 1973.