CMHC executive directors: their relations with federal, state, and local governments.

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CMHC EXECUTIVE DIRECTORS: THEIR RELATIONS WITH FEDERAL, STATE AND LOCAL GOVERNMENTS

A Dissertation Presented

By

ANDREA G. SODANO

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of

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Psychology Department
CMHC EXECUTIVE DIRECTORS: THEIR RELATIONS WITH
FEDERAL, STATE AND LOCAL GOVERNMENTS

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By
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ABSTRACT
CMHC Executive Directors: Their Relations With Federal, State and Local Governments
(February 1982)
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Directed by: David M. Todd

Community Mental Health Centers (CMHCs) have been the primary source of comprehensive mental health care in the community since the early 1960's. Their growth has been rapid and has often reflected the turbulence of the public sector and the political whims of the various governmental agencies from whom they receive the majority of their funding.

This research examines the role of the CMHC executive director in relation to federal, state, and local government. Utilizing structured interviews, nine CMHC directors in several states were interviewed about their relationships with the National Institute of Mental Health (NIMH), their state and federal legislators, their state departments of mental health, and their local governments. Topics discussed included individual relationships, problematic and positive aspects, methods of coping with the problems, strategies used to gain influence over the political and financial process, and alliance building, both personally and organizationally.
The most positive relationships existed with the NIMH. This resulted from the NIMH's ongoing involvement in the CMHC legislation, the provision of technical assistance, and funding via categorical grants. Relations with the state departments of mental health were more problematic, primarily due to their theoretical viewpoint, politics, and funding mechanisms. Local government rarely provided significant funding, thus creating accountability demands without providing financial support.

Support for the executive director came primarily from the NIMH project officers, other executive directors, and top management. Alliances were built with other agency heads, board members, and state and federal legislators. Strategies used to gain influence included coalition building, lobbying, appointment to committees, and community education.

During the process of this research, federal legislation supporting the CMHCs was drastically revised. The Mental Health Systems Act, which was the follow-up legislation to the initial CMHC legislation, was rescinded by President Reagan. The result is that federal money will now go directly to the states, with no funds specifically set aside for mental health. The consequence of this change is to put CMHCs in competition with other social, and possibly medical, services; withdraw their primary source of financial and organizational support (the NIMH); and place them in a much more politicized funding environment.
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APPENDIX A
CHAPTER I
INTRODUCTION

The purpose of this thesis is to examine the role of the Community Mental Health Center (CMHC) executive director in relation to the federal, state, and local government. Issues explored consist of an elaboration of who the players are, what the problems and positive aspects are in the relationships, what tactics and strategies are used in managing these relationships, and finally, where the alliances and sources of support are that protect the director from the inevitable stress of negotiating this very complex and turbulent system. The choice of studying CMHC directors and their relationship with federal, state, and local government grew out of an interest in understanding how the directors of large mental health agencies manage complex systems within which they are a part. The federal and state systems have been particularly important influences on the CMHC because of their central role in the provision of funding and the establishment of accountability and technical assistance requirements. Relations with both systems actually consist of two separate interactions, those with the National Institute of Mental Health (NIMH) or the state mental health authority, which are the funding and accountability arms, and the respective legislatures, which are the focus of lobbying attempts aimed at influencing large scale policy and legislation. While local government tends to contribute a limited amount of money to CMHCs, it also exerts accountability
demands and serves as a focus for lobbying attempts.

Through interviewing nine CMHC executive directors about their management of these complex and multiple relationships, it is hoped that a clearer picture will emerge concerning the external boundary role which is such an important aspect of the CMHC director's job.

To date, the majority of mental health administration literature focuses on the internal organization and the management of day-to-day activities, rather than the external environment and its impact on the functioning of the mental health agency. Furthermore, within the mental health administration literature, there is very little written on community mental health centers and their particular management dilemmas.

The remainder of this chapter will consist of a review of the relevant literature and a statement of the problem to be studied. The literature review will include two major sections: a history of the CMHC movement and problems experienced by the CMHCs. The problem section is further divided into: 1. the seed money concept, 2. relations with NIMH, 3. relations with the state, 4. relations with local government and agencies, 5. the complexity, uniqueness, and turbulence of the mental health environment, 6. the role and training needs of the mental health administrator, and 7. stress and burnout of mental health executives and social support as a mediation of this stress.
History of the CMHC Movement

The Community Mental Health Center program began to develop in 1963 as a result of increasing dissatisfaction with state mental hospitals and the need for accessible and comprehensive services. By 1965 federal legislative appropriations had been made to cover construction and staffing grants. The staffing grants (administered by NIMH) were to cover a period of 51 months with a sliding scale for staff coverage which would decline over the life of the grant. Specifically, the staffing grant provided a maximum of 75% of the center's initial costs, phasing down to 30% by the end of the grant. This "seed money" approach was designed to encourage the development of community mental health programs on a community level and to encourage collaborative planning and funding between federal, state and local governments. Upon expiration of the federal money, centers were expected to have broadened their funding base and be receiving enough money from state and local funds, private insurance, Medicare and Medicaid, and client fees to be essentially self-sufficient.

Requirements for receiving the construction/staffing grants consisted of providing five basic services: inpatient, outpatient, partial hospitalization, emergency, and consultation and education. Additional requirements included: serving a population of 75,000 to 200,000 people within a catchment area and coordinating with other mental health care providers in the state through the development of a state plan in order to prevent duplication of services.
Early in the development of the program it was clear that the centers were not going to become self-sufficient within 51 months. Therefore, eligibility was extended to eight years and designated poverty centers were allowed higher levels of funding.

By 1975 centers were still having problems becoming self-sufficient, so in that year Public Law 94-63 was established providing a new sliding scale for the newer centers and three year distress grants for older centers. However, P.L. 94-63 also required expansion of services from the basic five to 12 (an addition of children's services, elderly services, screening services, follow-up care, transitional services, alcohol abuse services, and drug abuse services). New time limited grants were developed to aid in the transition to these additional services. These included conversion grants supplemented by another type of distress grant and permanent grants for consultation and education services. This last grant was the first hint that it might be impossible to rely on the seed money approach in the development of CMHCs.

In 1978 there were additional changes in the CMHC legislation. The act was extended and provisions were made for centers to be able to receive up to five distress grants rather than the previous two and for them to keep a portion of surplus funds generated from year-to-year.

In 1980, the CMHC program was extensively revised with the passage of the Mental Health Systems Act, P.L. 96-398. The purpose of this legislation was to increase state government's involvement in the CMHC program, to bring needed services to unserved populations, and to
make the system more flexible while retaining the concept of comprehensive services.

For a more comprehensive view of the development of the CMHC program there are a number of books and articles to refer to. These include Foley, 1975; Gabbert, 1980; Joint Commission on Mental Illness and Health, 1961; Beigal and Levinson, 1972; Sharfstein and Wolfe, 1978; Naierman, et al., 1978; Morrison, 1977; and most recently, the Mental Health Systems Act, 1980. Now we will turn to an examination of the particular problems experienced by CMHCs and their implications for management.

**Problems Experienced by the CMHCs**

According to NIMH (1978) and Naierman, et. al. (1978), there are currently 675 CMHCs throughout the country with a total operating budget of 799 million dollars in 1977. Although the CMHC program has developed rapidly and has grown into one of the largest mental health care giving systems in the country, this growth has not been without its problems. These problems fall into several categories which will be discussed in the next seven sections of this paper. Included are the following: 1. the seed money concept, 2. relations with the federal government (i.e., the NIMH), 3. relations with the state government, 4. relations with local government and agencies, 5. the complexity, uniqueness, and turbulence of the mental health environment, 6. the role and training needs of the mental health administrator, and 7. stress and burnout of mental health executives.
and social support as a mediation of this stress.

The seed money concept. Several writers have discussed the seed money concept and its application to CMHC viability (e.g., Morrison, 1977; Gabbert, 1980; Naierman, et al., 1978; Sharfstein and Wolfe, 1978). It is clear that the seed money concept has been successful in establishing the CMHC programs. Through the initial federal investment, CMHCs have been built and staffed and the CMHC ideology of comprehensive services, available to all regardless of ability to pay, has become a reality. CMHCs have managed to link-up with the community in which they reside and have aided in deinstitutionalization attempts. They have also developed some alternative sources of funding. For example, in 1976 the NIMH indicated that the typical breakdown in CMHC funding was 35% federal, 25% state, 30% fee for service, and 10% other government sources (Morrison, 1977).

However, there are also problems inherent in the seed money concept which impact on the center's potential viability, the CMHC ideology, and the administrator's management ability. As has been discussed, the seed money program was established as a way of initiating comprehensive community mental health services, with the expectation being that other sources of funding (particularly state and local dollars and third party reimbursement) would become available as the need for, and availability of, mental health services became evident. Implicit in that assumption is that state and local government would be both interested in and willing to pick up the tab
and that they were in essential agreement with the CMHC ideology. Naierman, et al. (1978), in a study of CMHC self-sufficiency, suggest that this is not as true as was hoped. In fact, there have been many state and local governments which have been somewhat unwilling to provide needed funds. Furthermore, those that have supplied replacement funds have often done so with their own requirements attached, requirements which do not always mirror the CMHC ideology. Because of increasing reliance on state money (which often favors the chronically mentally ill) and third party payors like Medicaid, graduate CMHCs are gradually moving in the direction of increased services for the more severely disabled and fewer prevention services. Naierman, et al. feel that much of this shift is due to a lack of coordination with the state on the part of the NIMH officials. This subject will be discussed more fully in the section on relations with the state.

The shift away from the provision of comprehensive services as the federal money declines has been powerfully influenced by the reliance on third party payors such as Medicaid, Medicare, and private insurers. Their payment schedules grew out of a medical/health model where inpatient services, physician visits, and hospital outpatient services are funded more generously than outpatient mental health services. Thus, in order to receive reimbursement, CMHCs must fit into very specific guidelines concerning services provided, staff credentials, client eligibility, and type of organization. A further problem concerns reimbursement rate structures which often fail to cover actual
costs of outpatient care, whereas inpatient care is fully covered. In terms of Medicare, reimbursement for services to the elderly are even more medically/inpatient oriented. Private insurance, too, provides more incentives to utilize inpatient care and more expensive mental health personnel (e.g., psychiatrists and psychologists) than lower cost outpatient care.

Naierman, et al. raise an additional problem with the seed money concept. They suggest that the distributional aspects of the program have proven to be inequitable and not in line with the CMHC ideology. This results from treating all states identically and dispersing funds according to the pattern of applications. Because seed money requires an application from a coherent group, the initial CMHC grants tended to go to states which were either sophisticated grant seekers or were already invested in community mental health care. Also of some concern is the environment in which a center is established. Clearly a CMHC built in a state that has a friendly view towards community mental health and also has more flexible Medicaid/Medicare requirements is likely to fare better than those centers in more hostile or poor environments. The result may be some bias as to which states receive the preponderence of CMHC seed money.

A final problem with the seed money concept revolves around the uncertainty of continued funding. After the eighth year of support, a CMHC may lose up to a quarter of its total monies. This has serious implications for management planning. If one believes there will be no further funding, then expansion of services over the years may
not be attempted. On the other hand, if the manager believes further funds will be provided, s/he may be faced with dramatic cutbacks after the eighth year.

In summary, although the seed money concept has enabled the development of a vast network of CMHCs across the country, there have also been problems which have resulted from this particular initiation/funding mechanism. These include the question of state and local interest in providing financial and ideological support for the CMHCs, the influence of third party payors in shifting services away from the CMHC ideology, the lack of coordination and planning with the state, distributional funding problems, and difficulties in effective long-term planning.

Relations with the National Institute of Mental Health. Several authors have discussed the problems experienced by CMHC directors in relating to the NIMH (Gabbert, 1980; Naierman, et.al., 1978; Sharfstein and Wolfe, 1978). Federal guidelines indicate that the role of NIMH project officers is to include: "1. monitoring program development and financial planning at the center level, 2. providing consultation and technical assistance when needed, and 3. coordinating program planning efforts with state mental health authorities" (Naierman, et. al., p. 48).

Sharfstein and Wolfe discuss several problems inherent in this arrangement. Because the CMHC program is decentralized and administered regionally, there is a lack of national uniformity and a resultant subjectivity in the monitoring process. The regional NIMH offices
report to the Alcohol, Drug Abuse, and Mental Health Administration's (ADAMHA's) regional health administrator instead of to the central office of NIMH. Furthermore, the regional health administrator reviews all CMHC grant applications and awards and monitors grants. This structure leads to frustration and confusion, and difficulty in developing a unified national program. Other concerns involve the inherent contradictions in being both a regulator and a consultant, and in the deterioration in quality of NIMH project officers because of down gradings.

Naierman, et al. interviewed CMHC personnel about the extent to which NIMH representatives participated in centers' efforts toward program development and financial viability. A number of complaints were voiced about NIMH's relationship with the CMHCs. One significant complaint concerned the insufficient amount of time NIMH project officers spent with center personnel. Because the annual site visit is only one or two days, the amount of time available to provide technical assistance is severely limited, with most of the time being used for monitoring activities. The time constraints are further complicated by the predominately generalistic training of the project officers. Thus, requests for specific help (e.g., management, grant writing, research, alternative funding sources, or accounting) could often not be met.

Data requirements were generally seen as burdensome and irrelevant. Furthermore, NIMH's data requirements often conflicted with other funding sources' needs (e.g., different fiscal years used by
various funding agencies). Finally, the lack of coordination between state mental health authorities and NIMH was experienced as a problem by some of the centers. This will be discussed in the state section.

Problems discussed by Gabbert focused on complying with the federal regulations. The 1975 CMHC amendments, while trying to improve service provision, have, in fact, imposed additional problems for management. Requirements added include: increasing the essential services to 12, becoming more accessible and accountable to the community, and increasing reporting requirements to NIMH. The 1977 amendments helped increase financial viability a bit by allowing centers to keep a portion of their surplus funds which are generated from year to year, but the amount is small (5%).

In summary, relations with NIMH are supposed to provide a supportive framework within which the CMHC concept can be nurtured and developed. However, there are a number of problems inherent in this relationship. These include the following: 1. the decentralized structure of NIMH, 2. the insufficient amount of time spent by project officers with center personnel, their lack of specific technical expertise, and the inherent conflict in their role of monitor/consultant, 3. burdensome and conflicting data requirements, 4. the lack of coordination between the state and NIMH, and 5. complying with federal regulations.

Relations with the State. Just as with federal/CMHC relationships, CMHC interactions with the state can be problematic. Several authors
(Okin, 1978; Foley, 1975; Gabbert, 1980; and Naierman, et al., 1978) outline some of the problems, including: the states historical commitment to CMHCs and the problems with the seed money concept; the structure of the delivery system; and funding issues.

Before the CMHC act, states had played a prominent role in funding mental health services through state mental hospitals. With the advent of federal money for community mental health services, the states were given an incentive to turn their policies and commitment in the direction of CMHCs. The incentive was especially powerful in that the development of the program was to be a joint federal/state collaboration.

In fact, the states have been left with a tangential role. Although a state agency has to be designated as the planning and coordinating body for the development of CMHC services, the prioritizing of community needs has to be determined according to federal rather than state guidelines. Furthermore, even though funds are based on matching state contributions and the state is in the position of formally supervising and coordinating mental health services, the disbursement of funds goes directly to the CMHC, thus bypassing state and local government.

Although the state's role proved to be tangential, they were still willing to support the development of CMHCs because of the small investment initially required. However, once the federal funding and regulations are terminated, this supportive attitude may diminish and relationships between states and federally-funded centers may become
strained. Financial backing may decrease or disappear; CMHC program ideology may be forced to move in the direction of the state mental health ideology, often with an emphasis on the chronic population; and the centers may find themselves in competition with local agencies. Because a state/federal partnership was never established, the loss of federal funding and protective regulations plunges the centers into dealing with state mental health authorities who may be apathetic or even hostile to CMHCs. Furthermore, the states are faced with decreasing dollars, leading to a reassessment of their priorities and programs, and placing the centers in an environment of constant change, which inhibits long-term planning for programs and funds.

Naierman, et al. suggest that a significant influence on the functioning of a CMHC is the structure of the state mental health delivery system. They reviewed centers in both centralized and decentralized state structures. Their findings are:

"Centralized states free centers from local political patronage, have greater control over the flow of money to the centers, foster dependency on state priorities, and have clear lines of authority directly to the centers. Decentralized state structures tend to create continued lines of authority, subject centers to political patronage, and place the focus of activity on the local level" (p. 58).

In this environment the multiplicity of layers and the political atmosphere can prove to be cumbersome and frustrating.

The above authors also discuss the impact of various state funding mechanisms on the management of CMHCs. They list five types of funding mechanisms, which include: 1. grant-in-aid with no strings
attached, 2. grant-in-aid with differing priorities, 3. retroactive reimbursement for deficits incurred or 4. for service rendered on a per capita basis, and 5. fee as set by the state for unit of service. Fee for service seems to provide the most accountability, stability, and flexibility for both state and center. Grants-in-aid programs tend to encourage political manipulations and give a great deal of power to the funding authority. Retrospective reimbursement causes cash flow problems and offers little security for the center. Generally, Naierman, et al. found that state funding is much more open to political manipulation than is federal, and those centers having the most political influence fare the best.

In summary, relations with the state are often problematic for several reasons including: the states' historical and continuing emphasis on the chronic population, the lack of a state/federal partnership in developing the CMHC program, state structures which are cumbersome to work with, state funding mechanisms that create planning and cash flow problems, and working in a politicized environment.

Relations with local government and agencies. For the most part, funding relationships with local government (i.e., cities, towns, and counties) are somewhat limited and less important financially than relationships with the state and federal government. The exception to this is in states which are decentralized financially. In these states, centers are more tied to the priorities of local funding agencies and usually find themselves in a much more competitive and politicized
environment. Other problems experienced by centers who have to relate to local government on a regular basis include administrative bottlenecks and interference in the center's day-to-day activities (Naierman, et al., 1978). Because of the decentralized service delivery system, centers often have to contend with problematic or slow budget approval processes which affect the center's planning ability.

In discussing issues in funding community services, both Beigal (1971) and Flynn (1979) emphasize the importance of effective linking and communication with local government and a variety of community groups and agencies. The importance of this approach as a strategy designed to influence funding and policy-making bodies and to develop generalized support for the CMHC will be discussed more completely in a later section on politics and legislation.

Relationship building with local social service agencies is also an important role for the CMHC director and a source of potential problems. According to federal regulations, CMHCs are mandated to be a coordinating influence on mental health services in the community and to work cooperatively with those agencies. This can prove beneficial in terms of comprehensive service delivery and building of alliances. However, in the current financial climate, it can also prove to increase competition for scarce mental health resources.

In discussing mental health administration, the need for inter-agency collaboration and coordination by administrators is noted by numerous authors (Cohen, 1970; Foley, 1970; Feldman, 1978; Hilleboe
and Lemkau, 1969; Wellington and Bellis, 1976). Within this context the administrative role becomes one of negotiator and broker in a matrix of multiple and often conflicting forces (Freedman, 1972; Levy and Bernthal, 1967). Agranoff (1974) suggests that mental health administrators should be involved in the design, facilitation, and operation of comprehensive service networks; the establishment of interorganizational collaborative system mechanisms; the operation of public contact and information systems; the development of operational and evaluative systems, and the systematic planning for these activities.

Both Neugarten (1975) and Feldman (1972) emphasise the need for CMHCs to become increasingly interdependent and sensitive to other organizations and groups within their environment so that comprehensive, coordinated, and accessible mental health services can be provided. This is often thwarted, however, by the lack of goal consensus, unifying purposes, and unequal power among agencies. Agency directors often want to preserve or expand their own domain and lack a systems perspective, even though they are aware of the interdependencies in the environment.

Thomas and Vidaver (1972) feel that mental health services need to be integrated into an even larger coordinated network of complementary community facilities and preventive programs. These would include general health services, the police, courts, social and welfare agencies, and health institutions. Coleman and Patrick (1976) and Macht, Scherl, and Sharfstein (1977) emphasize the need for integrated
mental health and primary medical care services promoting more coordinated, accessible, and less stigmatizing treatment. Most recently, the Mental Health Systems Act (1980) has established funding for health/mental health linkage grants as a way of providing more comprehensive services.

Baker (1972), in discussing the necessity for extensive planning in the management of a CMHC, suggests that comprehensive planning not only involves concern for accommodation to future change, but also recognizes the interdependencies of the parts of the community mental health system. He sees the human service organization as an open system and defines it as a "bounded interacting set of subsystems engaging in an input-output commerce with an external environment in the processing of people, information, money, and material resources" (p.99).

Flynn (1979), in studying rural mental health administrators, found that linkages with various agencies proved to be important sources of community support and power. Specifically, the CMHC directors interviewed indicated that links with local and community governments, the board of directors, state legislators, local advocacy groups, school personnel, clergy, and the criminal justice system were the most helpful.

The preceding emphasis on linkages, coordination, and cooperation among mental health agencies ignores the significant problems associated with that approach. Franklin and Kettredge (1975), in discussing organizational relationship problems in community mental
health, emphasize the likelihood of overlapping domains with other agencies and resulting competing claims. This often leads to confrontation with other public and private organizations who claim the same domain.

Greenbaum (1969) compared six mental health leaders who resigned to five who did not. He found that one of the major reasons given for leaving the job was the frustration experienced in relating to the external environment, specifically boards, politics, and the community. Other frustrations mentioned included the loneliness of the job and being treated as an authority figure. See Sarason (1972) for an eloquent description of the loneliness and isolation of an executive.

Forrest, Johnson, and Ralston (1978) lists the large number of groups which mental health administrators have to relate to as part of their job. These include the following: 1. other mental health professionals (employees, colleagues, or interested professionals); 2. government agencies (mental health planners and policy makers), including federal, state, regional and local personnel, all of whom are responsible for the approval of mental health programs, budgets, facilities' development, and purchase of services; 3. consumer representatives and organizations; 4. other mental health agencies and associations; 5. physical health delivery organizations; and 6. the administrative group (department heads, coordinators, staff, and the board of directors). Role expectations come from all of these groups, creating a situation of role conflict and overload. The
result is increased stress and burnout, which will be discussed in a later section.

In summary, as a result of federal mandates and the need for local government support, there is an increasing demand on CMHC directors to relate to a wide variety of mental health and government agencies in the external environment. This places the CMHC director on the boundary of his/her organization and a large, complex, and turbulent environment. Both the role and the environment have their own peculiarities and stresses, which will be discussed in the next two sections.

The Complexity, Uniqueness, and Turbulence of the Mental Health Environment

Many of the problems associated with managing an effective CMHC have to do with the general mental health environment within which the CMHC is imbedded. Mental Health organizations are typically quite different from private sector and industrial organizations. These differences often create significant problems for those trying to run mental health agencies. Following is a discussion of these differences, their implications for the maintenance of a stable organization, and future trends.

Several authors have examined the differences in and peculiarities of human service organizations (Maloof, 1975; Hazenfeld and English, 1974; Feldman, 1972, 1975; Freedman, 1972; Flynn, 1979; Feldman and Cahill, 1975). It is agreed upon by these authors that there are a
number of special circumstances associated with the administration of a mental health organization.

Hazenfeld and English (1974) discuss the distinctive attributes and problems common to human service organizations. In contrast to most bureaucracies, raw materials to be worked with are not value neutral; they are human beings. Goal definitions in human service organizations are ambiguous. There is no consensus on the ideal goal and goal definitions are ideological in nature. Human service organizations must cope with the personal goals of their clients as well as their own. The technology of human service organizations is indeterminant; clients as raw materials present a higher degree of uncertainty to the organization. They also tend to be a dependent population which is easily stigmatized. Staff-client relations are the core activities within the human service organization and the transactions are private. Human service organizations rely extensively on professional staff that is multidisciplinary, autonomous, and rivalrous. These organizations lack reliable and valid measures of effectiveness. This is a result of the lack of clear definitions of desired outcomes and inadequate knowledge about cause-effective relations. Measures of effectiveness, therefore, become extrinsic rather than intrinsic.

Feldman (1972, 1975) discusses several additional attributes of human service organizations. Public funding is from many sources with numerous government regulations associated with the funding. The boundaries of the field are difficult to define and administrators
need to do a great deal of inter-organizational work. Programs within the community mental health system tend to be decentralized, with an emphasis on consumerism and community involvement.

**Funding.** The multiplicity and changing priorities of funding sources has a fragmenting effect and constrains national mental health planning and priority setting. Funding methods will be constantly changing, with decreased federal support, increased pressures to maximize reimbursement, and the need for more diversified bases of funding. Future implications of these trends include the following: 1. uncertainty and conflicts between the priorities of different funding sources and actual local needs; 2. problems with staff's lack of understanding of fiscal pressures and the resultant difficulty in implementing procedures to increase client or third-party reimbursement; 3. difficulty in securing funds for nonallowable costs and services; 4. the need to develop working relations with a variety of organizations; 5. the elimination of certain disability groups because their needs do not meet funding requirements; and 6. reduction in administrative leadership and flexibility in setting priorities. The different funding regulations and standards will lead to periodic and continuous readjustment of goals, personnel, and programs in order to secure funds. Increased competition among human service providers for funds will result in little cooperation, fewer services, and tense interagency relationships.
Accountability. In discussing the topic of accountability, the prediction is for increasing demands toward more detailed information and data collection. There is some concern that increased community participation in mental health planning and services by residents and local officials may create role blurring and a climate of tension with regard to responsibilities and program ownership.

Services. The discussion of services emphasizes a trend toward community based care to continue. Difficulties are seen in maintaining resources and a balance between primary, secondary, and tertiary services. There will be increasing pressure to develop a wide range of services for both the chronically ill and healthy. Service related problems are seen to include the following: 1. the creation of budgetary structures that will support a balanced approach; 2. insuring that staff be familiar with innovative service models; 3. changes in staff recruitment, selection, training and supervision; 4. the development of individualized program evaluation criteria and methodology for each service element; 5. the judicious use and coordination of fiscal, technical, and staff resources of both public and private agencies; 6. the need to integrate mental health services with primary and holistic health systems; 7. the increased need to more adequately define mental health service boundaries; and 8. the need for individual service programs to reflect local needs, resources, and conscious choices by local program administrators and community residents.
Policy and legislation. With regard to policy and legislation, the conference participants felt there would be difficulty in determining future federal mental health policy and its impact on service providers. They thought, that faced with rigid policy or the absence of policy alternatives, administrators may be perceived as arbitrary, insecure, or lacking in knowledge, which would lead to problems with staff morale and erratic behavior by boards.

Mazade suggests that other problems to be dealt with include shifts in funding from federal to state levels, uncertainty about National Health Insurance, greater emphasis on community control, and lack of consensus regarding the type of personnel required. The most significant problem is that the ambiguity of the mental health environment leads to a perpetual state of decision-making under conditions of uncertainty.

It is clear from the above discussion that CMHCs must operate in an exceedingly complex, changing, and turbulent environment. In order for them to survive they must adapt to the environment in such a way as to acquire and maintain sufficient levels of resources. Baker (1972) suggests that because of the complex, dynamic environment, effective planning must take a longer range view. He describes two types of strategic planning approaches, the inside-out versus the outside-in approach. The first begins with the abilities, aptitudes, and desires of the members of the organization and then looks to the outside environment for opportunities to utilize special organizational strengths and satisfy particular needs. The second begins
with a survey of the environment and an assessment of present conditions, the forecasting of future events based on an analysis of the outside. The executive then examines the inside of the organization for strengths and weaknesses in determining which of the opportunities or needs in the environment to try to meet. Environmental changes can be anticipated by the commitment of staff resources to the surveying, forecasting, and analyzing of the external environment. Baker feels that it is the manager's job to monitor both internal and external organizational changes or establish a system which will do the monitoring for him/her in order to protect the organization from the whims of the environment.

In summary, managing a human service organization in the public sector is fraught with numerous demands and dilemmas. Many of the attributes of human service systems make it difficult to develop funding sources, define goals and successes, or to defend the nature and quality of the work. The internal processes of the human service bureaucracy are exposed to both the consumer and politician, creating numerous pressures on the administrator. The CMHC director's environment is complex and includes: staff, elected officials, legislative demands, other agencies, boards, various levels of government, interest groups, political parties, citizen groups, clientele, and various funding sources. It is within this network that CMHCs must attempt to accomplish their often vaguely defined tasks.

Being in a job where one has to deal with often perpetual ambiguity, a multiplicity of responsibilities, numerous interagency relationships,
and complexity internally and externally (particularly in relation to funding and governmental relationships) clearly contributes to the amount of stress experienced by a mental health administrator. One factor in this stress is the lack of training in mental health administration and the professional socialization that is characteristic for most mental health administrators. The role and training of the mental health administrator will be discussed in the next section.

The Role and Training Needs of the Mental Health Administrator

The role of the mental health administrator involves a multitude of tasks, various demands, and certain problems which must be confronted daily. In the following subsections, these issues will be discussed. Included are: 1. the tasks of the mental health administrator; 2. the socialization of the clinician-executive; 3. the conflict between professionals and administrators; 4. the issue of power and politics; 5. boundary spanning; and 6. training needs of mental health administrators.

The tasks of the mental health administrator. Most of the literature concerning mental health administration (c.f., Feldman, Goldstein, and Offutt, 1978; Hinkle and Burns, 1978) is a description of what the mental health administrator should be doing, his/her job tasks. Earlier literature, especially that written by psychiatrists about the administration of mental hospitals, tends to focus on internal management of
the organization and the development of an environment conducive to
treatment (Group for the Advancement of Psychiatry, 1960; Levinson
and Klerman, 1967; Nordstrom, 1966). An important theme in this
literature is the necessity for developing an environment and communica-
tion channels with the aim of accomplishing organizational goals.
The psychiatrist's training in relation to the understanding of
motivation, listening, patience, flexibility, and group process are
seen as instrumental in the accomplishment of this task (Sheffel and
that staff development is a crucial role for the mental health
administrator. Most of these authors feel that flexibility, permis-
siveness, and the establishment of good communication channels is
critical in relating to staff. Another prominent theme concerns the
establishment and management of informal communication channels as
a way of monitoring the organization.

Major managerial tasks as discussed by this group of writers
consists of a variety of jobs. Defining and communicating explicit
institutional objectives (short, intermediate, and long range); attain-
ing and maintaining productivity consonant with these objectives;
achieving and maintaining accountability for people, property, and
personal and institutional performance; and evaluating programs are
all seen as important aspects of the job by Reese (1972). Levinson
and Klerman (1967) and Schwartz and Schwartz (1967) define the job as
one of recruiting and training staff, creating conditions that facili-
tate effective work by the staff, obtaining money, mediating disputes,
and generating new programs, policies and goals.

Turning to more traditional private sector management theory, a variety of functions are seen as central to the manager's job. Planning, organizing and coordinating, staffing, directing, controlling and reporting, innovating, and being a representative to the outside are considered essential aspects of the job by Dale (1973). Bernard (1938) suggests that an organization is best managed by maintaining communication, formulating purposes and objectives, and securing essential services. Newman (1963) feels that assembling resources and directing are the major components of managing. Foley and Brodie (1969) indicate that decision making is the common denominator of all administrative functions. Anticipation of the future and attempts to mold it and balance short-range and long-range goals are essential according to Drucker (1973). As with the literature on the administration of mental hospitals, much of the traditional private sector management literature focuses on internal aspects of the organization, viewing the establishment and management of relationships with the external world as secondary.

As the community mental health movement, with its emphasis on collaboration and citizen involvement, became more of an influence, and as the financial situation changed to one of multiple sources of funding and accountability, writers (e.g., Feldman, 1974; Kovner, 1972; Steger et al., 1973; Steger, Manners, and Woodhouse, 1976) began to focus more on the external environment of the organization as a place where mental health directors should be spending time and energy. For
the most part these authors did not dismiss the tasks of internal management, but rather saw them as half the job, with an emphasis on external management gaining in importance. CMHC survival was becoming an important issue (c.f., Gabbert, 1980; Beigel and Levinson, 1972; Sharfstein and Wolfe, 1978; Whittington, 1975), leading to an increased emphasis on relationships with the external environment, particularly in relation to funding and accountability.

Flynn (1979) sees the CMHC director's role as consisting of three parts. The first is that of internal manager, which includes program design and administration, staff recruitment and supervision, clinical care responsibilities, and organizing the budget. The second involves community relations, including relating to different cultures and groups. The third part consists of working with other agencies and dealing with the resultant antagonisms, competition, and collaboration. The necessity of developing linkages is also an important part of the CMHC director's job.

Neugarten (1975) also writes about interorganizational relations and the external environment. He sees the administrative tasks of a CMHC director as consisting of: 1. the generation and allocation of funds; 2. the recruitment and training of staff; 3. the development and integration of treatment programs and patient information systems; 4. the cultivation of political and community support; 5. the dissemination of information about community needs and resources; 6. consultation with other organizations; and 7. the evaluation of organizational effectiveness.
Mazade (1978) suggests a deemphasis on intraorganizational issues and more of a focus on external factors, specifically organizational boundaries and interorganizational relations. He feels needed skills include negotiating, bargaining, community organizing, arbitration and mediation, coalition building, priority setting, marketing, planning, lobbying, public relations, and advocacy.

In summary, early writers, in discussing mental health administration, primarily focused on the management of the internal organization (e.g., communication channels, staff development, planning and decision making). As the CMHC movement began to develop, with its emphasis on linkages, multiple sources of funding, and accountability, the focus of the mental health administration literature began to shift toward the need for skills in managing the external environment. However, before that aspect is discussed in more detail (i.e., power and politics, and training needs), it is important to discuss two potential problems facing the mental health administrator. The first is the socialization of the clinician-executive and the resultant implications for management efficacy. The second is the potential conflict inherent between professionals and administrators.

The socialization of the clinician-executive. Many mental health administrators have emerged from the ranks of clinicians, thus the title clinician-executive (Levinson and Klerman, 1967). This transition from clinician to executive brings along with it many problems as well as some assets. Much of the literature has been split over the efficacy of the clinician-executive role, arguing either for or against

On the negative side, Pattison (1974), in studying ten young psychiatrist/administrators, found that typically the psychiatrist is acculturated into a professional and personal style of role functioning that is dissonant with the skills, knowledge, and personal style required for the administrative role. In particular, the training of a psychodynamic clinician does not necessarily translate to the administrative role. In fact, that orientation may cause more role strain by requiring the executive to be quite active, define tasks, make decisions, and create plans.

Moore (1970) suggests that it is usually necessary to have established professional qualifications to be eligible as an administrator, yet there is often nothing in one's formal training to qualify for that role. If a professional wants administrative rather than advisory authority then s/he must take a diagonal move. There are several problems related to this move. Other professionals may see the administrator as having gone over to the enemy since s/he now represents organizational interests. Because of the rapid change in knowledge, s/he may lose professional authentication. S/he is entering a new occupation rather than a new position, resulting in new role relations. Resulting role conflicts include the autonomy of the professions, professional loyalty versus administrative requirements, and managing alliances with former peers.
On the positive side, Hawkes (1961) feels that the psychiatric executive is in a good position as an administrator because of the ability to bridge gaps and represent mental health needs to the legislature, and fiscal needs and problems to the mental health staff.

Kolb (1969), Levinson and Klerman (1967, 1972), Squire (1970), and Wachtel (1966) all feel that training in interpersonal dynamics, mental illness, and personality dynamics can be helpful in running an organization. However, emphasizing the psychotherapeutic approach to the exclusion of others can lead to pathologizing staff members, losing an overview of the broad organization, having difficulty with the authority role and with intradisciplinary conflict, and problems in relating to external organizations.

Bindman (1970) suggests that there are a number of components within a psychologist's training which are helpful to his/her role as an administrator. The ability to understand personality and behavioral dynamics helps with the assessment of people and situations. Consultation training helps in understanding the systemic nature of the organization. Research training helps in gathering epidemiological data for program planning. Finally, knowledge of group process aids in managing a team and utilizing problem solving techniques.

Beigel (1975) is concerned that the transition into the role of psychiatrist/administrator may make the person feel like s/he is not a member of either the clinician or the executive group. Socialization and training emphasize the primary care giver role, but in the
role of administrator the importance of programs is stressed. He feels the role of psychiatrist/administrator is particularly threatening to other psychiatrists because they see it as demeaning the importance of psychiatry, threatening private practice, and monopolizing all publicity through community programs. Beigel suggests that the conflict can be lessened between psychiatrist/administrator and psychiatrist through mutual involvement. Freedman (1972, 1972b) and Reese (1972) focus on the low status attributed to mental health administrators (particularly psychiatrists) and the resultant role conflict which they experience.

Greenblatt (1971, 1972) indicates that most mental health administrators are trained to be clinicians, which does not necessarily qualify them to be good administrators. Other problems include stress, physical and mental demands, brief tenure, and an uncertain future. Greenblatt and Rose (1977), in interviewing twenty executive psychiatric administrators, found that the administrators felt their psychiatric training had been helpful in sensitizing them to the interplay of individual and group dynamics. However, there were many stresses associated with the role, including: setting priorities under conditions of scarce resources; dealing with a large amount of responsibility, but with relatively little control; and coping with the slow pace of change, high visibility, the strain on family life, fatigue, and loneliness. There were also rewards, including: autonomy, self-growth, challenges, the variety of people one meets and works with, prestige and recognition, power, and contributing to mental health on a broad front.
In summary, although the clinician-executive may be aided in the management of an organization by his/her clinical skills, s/he is also faced with many problems. Peers may resent the role and attribute it with low prestige. Psychodynamic training may lead to pathologizing the organization, and not being active and directive enough in program planning and managing. There may be difficulties in feeling comfortable in the authority role. Role conflict and role strain may be experienced because of the ambiguity and multiplicity of roles required and the lack of training in various administrative functions.

The conflict between professionals and administrators. Many authors have written about the concept of professionalism (c.f., Arnold, 1971; Cheek, 1967; Parsons, 1939; Dolgoff, 1975). A professional is defined as a person in a socially approved occupation who requires a long period of formal training in a specialized field. There exists a code of ethics, a strong service ideal with correspondingly low profit motives, an expertise manifested by symbols (e.g., licenses), and a confidential relationship with clients. There is a unique body of knowledge and the setting of standards for education, ethics, and practice. Assessment of work is by professional peers. The professional has a sense of identity, shared values, and a common role definition and language. His/her status tends to remain constant once it is achieved and there is a norm of autonomy and controlling one's work.

Dolgoff (1975) stresses that in an organization the professional tends to create his/her own role and wants control of the working
conditions as much as possible. Professionals derive their rewards from standards of excellence dictated through their professional identification. They are committed to the task, not the job, and to the standards, not the boss. Colleagues and professional associations, rather than the place of work, become the reinforcement. The resultant difficulty for the mental health administrator is that mental health professionals may tend to resist the authority of hierarchical supervisors because of their norms and self-concept as professionals. Because of their status, professionals tend to gravitate close to the center of authority, creating problems in managing the resulting informal alliances (Levinson and Klerman, 1967). There is also potential for administrator-professional conflict because of their differing perspectives and organizational roles (Cohen, 1970).

In summary, while managing the external environment is become more difficult because of its increasing complexity, so, too, managing the internal organizational affairs is a challenge because of the professional identity of most of the staff. At a time when the exigencies of funding require a cohesive, goal oriented organization, the increasing emphasis on professionalism and the consequent competition make that a difficult goal to accomplish.

Power and politics. A number of articles written about mental health administration address the issue of authority and power. Levinson and Klerman (1972), Racy (1975), and Zaleznik (1967) all agree that the central task of an administrator is power consolidation and dispersal.
The leader must translate authority into power and that power into influence. Dalton et. al. (1968) make a useful distinction between positional and professional authority. The former is seen as the right of an individual based on his/her position to direct the activities of others. The latter refers to influence gained through specialized knowledge and expertise. Often a CMHC director holds both types of authority at the same time, a situation which may simultaneously increase the director's power and create role conflict.

Levinson and Klerman (1972) indicate that mental health executives must have an interest in generating and using power and managing the external boundaries. They need to create appropriate boundary structures to insure the necessary flow of inputs and outputs. Internal operations must be delegated to others, resulting in employees having limited direct contact with top management. Those working on the boundary will need extensive skills in negotiation since they have much less authority, if any, in the external environment than they do within the organization.

In discussing the topic of power Felzer (1970), Racy (1975), and Dalton et. al (1968) suggest that the internalization of the authority/power role may be particularly difficult for the clinician executive. Although clinicians have had experience in dealing with power issues on an individual/client level, they are less experienced at confronting power issues on a larger, systemic level. Because of their socialization and training, they may be more ambivalent and less adept at handling the routine challenges and politics inherent in an organization.
Enelow and Weston (1972) suggest that the administrator's role is to see that power is shared both within and without the organization. They feel that staff should be involved in developing administrative structure and shaping policy. Externally, a CMHC director should involve the community in the development of programs. The sharing of power, however, can be accompanied by a number of problems involving, for example, the funding process, the balance of forces among groups, and rivalry among mental health disciplines, private and public agencies, and staff.

Pertinent to the discussion of power is an article by Perucci and Pilesuk (1970). They found that those individuals studied within a certain community had more or less power based on their placement within the web of a network. For example, those who sat on more boards tended to have more power. These people, called interorganizational leaders, had frequent social ties, similar values, and were seen by others as having more power.

Related to the issue of power is that of politics. Several authors, in describing the role of the mental health administrator, mention the need for involvement in politics (Hirschowitz, 1971; Johnson and Forrest, 1979; Kaufman, 1969; Mott, 1969; Ulett et al., 1971). Freed (1967) feels that a community psychiatrist cannot avoid immersion in politics and attempts at influencing decision-makers and community leaders. He suggest it is important for mental health professionals to represent the view of mental health programs to legislators and the community. As important as it is to be involved in politics, it is not
an easy task for the clinician-executive (Pattison, 1974). The political system is an adversary system, involving power tactics, vested interests, currying of favor, and the use of the media (Greenblatt, 1974). It is a process that is very different from the socialization one receives as a mental health professional and is often seen as corrupt and unsavory by one's peers. Thus, the practice of politics becomes a potential source of role conflict.

Several authors (Armstrong, 1980, 1980b; Byrne, 1980; Beigal, 1971; Gabbert, 1980; Dorken, 1981; Robbins, 1980) suggest a variety of ways to gain power and influence, and effectively manipulate the political system. The three ways felt to have the most impact include lobbying with legislators, coalition building, and using key people on the board of directors as influence agents.

Lobbying efforts usually go hand-in-hand with coalition building, since lobbying is most effective when it represents a large number of constituents. In addition, lobbying is most successful when it is data based and includes background information that is well presented. Examples of coalition building include working with other local agencies, developing ties among CMHCs on a state, regional, and/or national level (e.g., the National Council of Community Mental Health Centers), and joining already formed coalitions on a local or national level (e.g., the National Association of Mental Health).

Gabbert indicates that the board of directors is central to the CMHC concept of community participation. All centers are required to have them. They are there to oversee policy development, hire and/or
fire the executive director, insure the CMHC meets the needs of the community, and help the director guarantee the center's survival. Because board members usually represent a range of community people and are often leaders within that community, the director can use them as influence agents in his or her lobbying and community building efforts.

Beigal (1971) suggests several other methods which can be used to influence the community, legislature, and funding groups. These include the effective publicizing and use of the CMHC emergency services, the use of the media as an advertising and educational tool (see Sodano and Brennan, 1978), publishing annual reports and having open community meetings, and loaning facilities to community groups.

In summary, the role of the mental health administrator is becoming increasingly complex. It is taken for granted by most authors, both traditional management theorists and mental health administrators, that a significant portion of the job consists of managing the internal aspects of the organization. However, as the community mental health movement has grown and more emphasis has been placed on CMHC survival, requirements of the CMHC director's job have increased to include managing much of the external environment as well. As mentioned above, this includes developing and distributing power, dealing with politics (including lobbying and coalition building), and relating to community boards, various funding sources, government bureaucracies, community groups, and other mental health agencies. This requires the CMHC director to function on a multitude of differing and sometimes conflicting,
boundaries. In the business literature this role is referred to as boundary spanning and has certain implications concerning job satisfaction, power, and stress. These issues will be discussed in the next subsection.

**Boundary spanning.** In examining the organizational literature, it becomes clear that environmental influences on an organization play a potentially significant part in shaping the organization and roles within it (c.f., Lawrence and Lorsch, 1967; Miles, 1980; Emery and Trist, 1965). Of particular relevance for CMHCs is the impact of an uncertain and rapidly changing environment. Because of lack of information about future events, the outcome of present decisions becomes unpredictable. This unpredictability is increased by an interconnected and dynamic environment, similar to that of a CMHC. The organizational role needs, generated from this type of rapidly changing and uncertain environment, are for people to fill boundary spanning and environmental monitoring roles.

For a comprehensive review of the boundary spanning literature, see Aldrich and Herker, 1977; Leifer and Delbecq, 1978; Miles, 1978, 1980; Miles and Perreault, 1976; Organ, 1971; Keller and Holland, 1975; Adams, 1976; Kahn et. al., 1964. Boundary spanning roles have a number of unique characteristics which lead to both gratification and stress in a job. The role links two or more systems whose goals and expectations are likely to conflict. The role occupant cannot rely on formal authority except within his/her own organization. Because of moving back and forth across the boundary, the person is more distant,
psychologically and physically, from the organization. This distance also puts the person in the position of 1. being both the source and target of influence attempts, 2. receiving conflicting expectations and experiencing distrust and suspicion from the various systems, and 3. having difficulty in evaluating one's job.

Boundary spanning activity serves a variety of institutionally adaptive functions. The person manages the "face" of the organization, processes environmental information, manages relations with environmental elements, and links and coordinates activities between organizations.

The benefits of this role for the individual are enhanced power, visibility, and exposure to a variety of problems and opportunities, leading to increased job contacts and possibilities. The same tasks that give a person power also increase the level of job conflict and stress. While one gains power from operating on the boundary, s/he also experiences increased ambiguity, conflict, and overload, all contributors to high levels of stress (Kahn et.al., 1964). These authors suggest that support and an alleviation of stress may result from professional identification with others in a similar role where techniques for resolving conflicts and reassurances about the commonality of the problems can occur.

In summary, CMHC directors are clearly boundary spanners, representing their organizations to a variety of external systems. They do this within the context of an uncertain, complex, and constantly changing environment. As a result, they presumably experience some stress in
their role. Additional stress may result from the limited management training most CMHC directors possess, a topic to be discussed in the next subsection.

Training needs of mental health administrators. Many of the authors mentioned in this dissertation have called for extensive and continuing training in mental health administration. They all feel that mental health organizations cannot be managed competently unless there is more emphasis on management training. Most suggest the need for training which is somewhat alien to mental health professionals - the study of politics, power structures, publics, policy, networks, planning and policy making in human service systems, management, interagency relationships, and service delivery models (Forrest, Johnson and Ralston, 1978).

Two studies looked at mental health executives and their training and skill needs. Flynn's (1979) rural mental health administrators expressed a desire for training in management theory, fiscal management, organizational development, economics, power, policy development, and recruitment of staff. The service provider executives studied by Johnson and Forrest (1979) elaborated on five necessary skill areas. The first is financial management, particularly as it relates to budgeting and a total process of forward planning for the organization. The second includes personnel management and supervision. The third requires some client-oriented experience and an ability to coordinate different components of the organization. The fourth area relates to
public relations skills and a community orientation. The final skill required is political science, specifically, understanding the political process.

Several authors describe particular training programs in community mental health administration (c.f., Kaplan, 1972; Schwartz and Schwartz, 1967; Wellington and Bellis, 1976). Feldman (1974), in describing a curriculum for masters and doctoral level students in mental health administration, suggests a number of substantive areas to be covered. These include the history and philosophy of mental health program development, mental health economics, mental health program evaluation, community mental health, executive administration of mental health programs, government processes and intergovernmental relations, social foundations of mental health, and organizational and interorganizational behavior.

Neugarten (1975) has developed an interorganizational relations training program for community mental health administrators. It covers the analysis of mental health service systems, the mapping of the broader interorganization field, an analysis of interorganizational relations, and a look at alternative future systems of mental health care. Hallenbeck et. al. (1977), in teaching CMHC management, use a computer model of a typical CMHC as a training device for graduate students learning to manage complex social agencies.

In summary, the role of the mental health administrator requires skills in a variety of areas. The executive must be adept at managing the internal aspects of the organization, including the inherent
conflict between professionals and administrators. S/he must also be competent as a boundary spanner, dealing with power and politics and relating to numerous agencies, government bodies, and community groups. As a result of professional socialization and a lack of training in administrative skills, many CMHC directors find themselves in a difficult position, where they experience a great deal of stress and, ultimately, burnout. The next two sections address the issue of stress and burnout for mental health executives and suggest that the notion of support may prove to be a beneficial mediator of stress.

**Stress and Burnout and Social Support as a Mediating Factor**

Feldman (1973, 1974) indicates that there is a severe shortage of competent mental health executives. At the national level the average tenure for a mental health administrator is eighteen months and the reported job satisfaction is lower than comparable educated managers (Perlman, 1978). Most authors feel this is a consequence of the role strain which results from moving from the status, functions and role of clinician to that of an administrator, integrator and promoter; dealing with the particular characteristics of the public sector. The result is often cognitive conflict, identity uncertainty, stress, and role strain (Greenbaum, 1968; Greenblatt, 1972; Greenblatt and Rose, 1977; Hirschowitz, 1971; Levinson and Klerman, 1967; Maloof, 1975).

Both Harrison (1978) and Karasek (1979) suggest that stress is particularly likely to occur when one's abilities and skills are not sufficient to meet perceived or real organizational demands. A
limited ability to make decisions, coupled with high job demands, also results in elevated levels of stress. These situations occur frequently for CMHC directors, leading to an often stressful job environment.

The concept of role strain is comprehensively discussed in the literature (c.f., Goode, 1960; Kahn, 1973; Kahn and Quinn, 1970; Sarbin, 1968). Role strain is usually seen as consisting of three components, role conflict, role ambiguity and role overload. Role conflict is the simultaneous occurrence of two or more role expectations such that compliance with one makes it more difficult to comply with the other. Role ambiguity is a discrepancy between the amount of information a person has and the amount needed to perform the role adequately. Role overload is defined as insufficient resources to meet role expectations. Thus, for the individual involved, the primary concern is coping with the strain which evolves from the management of a number of different roles and/or expectations.

The concept of burnout is related to that role of strain. Perlman and Hartman (1979) define burnout, also seen as stress, as overload and frustration, a conflict between two needs or valued goals, and pressure. Freudenberger (1975) defines burnout as wearing out, failing, and becoming exhausted. It occurs when there are excessive demands on energy, strength, or resources. Maslach (1976) focuses on the detached, dehumanizing feelings which may accompany burnout and suggests that it is a response to chronic personal and organizational tension and stress. Not having control over one's work can
lead to exhaustion, negative attitudes toward oneself and clientele, and lowered job performance. Cherniss, Egnatios and Wacker (1976), in interviews with public sector professions, found role conflict and ambiguity prevalent.

Many people have written about the role of social support in coping with life challenges (e.g., Caplan, 1964, 1974; Craven and Wellman, 1973; Davis, 1974; Klovdahl, no date; Sarason, 1977; Speck, 1967). A number of authors have focused on kin as social support (e.g., Bott, 1971; Craven and Wellman, 1973; Nelson, 1966). Others have focused on the development of support during major academic transitions (Coelho et. al., 1963; Orth, 1963; Mechanic, 1962; Sodano and Gabbert, 1975), while several have examined support in the context of informal helpers (e.g., Caplan, 1960; Silverman, 1969).

The quality of the emotional and instrumental, task-oriented, support provided by the social network within which the individual resides is an important factor in successful coping. Components of support which seem to be important are help by significant others with mobilizing psychological resources and mastering emotional burdens; sharing tasks; providing the person with extra supplies of money, materials, information, tools, skills, and cognitive guidance to improve his/her handling of the situation. Support systems can offer guidance to an individual through assistance in interpreting environmental cues and act as a refuge when stability and comfort are needed. Most often support involves an enduring pattern of relationships that help the person maintain well-being over time.
Another set of literature focuses on social support within the organization and its use as a mitigator of and buffer to harmful organizational stressors (c.f., McMichael, 1978; Cassel, 1976; Cobb, 1976). This group of writers tends to see occupational stress as the product of an interaction between persons and their work environments, with the reduction of stress entailing the modification of both persons and the work organization (c.f., French, 1973 for a discussion of person-environment fit).

House and Wells (1978) focus on support as a mechanism for mitigating the deleterious effects of occupational stress on health. They suggest that social support consists of having a "relationship with one or more other persons which is characterized by relatively frequent interactions, strong and positive feelings, and especially perceived ability and willingness to lend emotional and/or instrumental assistance in times of need" (p. 9). They suggest that supportive social relationships with superiors, colleagues, and/or subordinates at work, and also those outside the work setting, should reduce levels of occupational stress (e.g., role conflict and ambiguity, job dissatisfaction, and low occupational self-esteem).

House and Wells cite research (Gore, 1963; and their own) that suggests stress can be alleviated through social support. Gore, in a longitudinal study of the consequences of job loss and unemployment, found that perceived stress resulting from unemployment produced elevated cholesterol levels, increased incidents of illness, and constant depression among men with low social support, while
those with higher levels of social support were protected from these consequences. House and Wells found that social support derived from one significant other can be quite effective in mitigating the effects of stress on health; and, in fact, support from additional sources may have little or no additional benefits.

In summary, the research seems to suggest that social support can be beneficial in alleviating the harmful effects of stress, whether it be a result of particular life challenges or occupational stress. The results of this research point to the usefulness of exploring this concept in relation to CMHC directors, who are apt to experience a great deal of stress.

Summary and Statement of Problem

The role of the CMHC executive director has changed dramatically over the last fifteen years. The community mental health movement has grown substantially during that time to where it is now a multi-billion dollar a year business. The administrative tasks of the CMHC director have grown proportionately. The job has increasingly become one of managing an extremely complex organization within an even more complex and turbulent environment.

Early in the community mental health movement substantial monies for both buildings and staff were assured through generous funding by the federal government. Although there was supposed to be active collaboration between the CMHCs and federal, state, and local governments to develop various sources of revenues, in fact, reliance for
funding was concentrated on the federal government. For the most part, insufficient planning was done by CMHC directors to ready themselves for the shrinking federal dollars as they progressed through their eight years of staffing grant money. As the CMHCs have come to the end of their federal staffing grants and as money has become increasingly difficult to obtain, CMHCs have had to turn to state and local funds. These funds are often accompanied by service requirements and priorities which conflict with CMHC objectives. In addition, accountability and reporting requirements tend to differ with the different government agencies.

To complicate the picture further, current federal legislation is placing increased emphasis on deinstitutionalization, giving more power to the states over CMHC funding and evaluation, and relaxing the notion of comprehensive services to allow funding of single high priority services. This legislation would change the funding and accountability picture dramatically, possibly seriously compromising the CMHC ideology of the provision of multiple services to the entire population. The multiplicity and changing priorities of funding sources lead to difficulties in mental health planning and priority setting and a need to develop more diversified bases for funding.

The complexity of the CMHC director's job is not just limited to relations with the various levels of government. As the CMHCs have grown so has the number and diversity of staff, creating more complexity, ideological differences, and competition within the organization. Externally, citizen involvement with its advisory/governing boards
and increased participation by community groups may lead to a climate of tension. Involvement in politics and legislation is becoming a requirement if one is to have any influence concerning the future course of mental health. The boundaries of community mental health services are becoming increasingly difficult to define, both ideologically and territorially. Finally, there is the director's colleague group - other center directors, service providers, and fellow members of his/her profession. While these colleagues can provide support, collaboration, and education, they can also introduce an additional competitive component and, in rural areas, may be somewhat inaccessible. The result of this complexity is that the CMHC executive director has to become a boundary spanner, relating to numerous agencies, professional groups, peer groups, funding sources, etc.

This boundary spanner role has both positive and negative aspects. Organizationally, Miles and Snow (1978, cited in Gabbert, 1980) suggest that boundary spanners serve as primary links between the organization and the environment. Because of this, organizational structure and process can be adjusted to fit with environmental needs and demands, and/or attempts can be made to manipulate the environment to bring it into conformity with what the organization is already doing or wants to do. Basically, the director as boundary spanner serves the role of environmental scanner and influencer. One is constantly having to confront an environment which is complex, uncertain, changing, and sometimes hostile, while at the same time managing the internal organization which has similar qualities to the external environment.
It is clear that the CMHC director has to relate to a complex, uncoordinated, highly politicized environment of interdependent groups which often impose conflicting demands on the CMHC and affect its resource acquisition and service provision. It is critical for organizational survival that the director understand and work with the totality of this environment so that effective planning can be implemented. However, there are some relationships which are particularly important and have substantial impact on CMHC survival. These key relationships are with the federal, state, and local government, since they are the ones who are primarily responsible for funding, policy, accountability, and evaluation; all tasks which are central to CMHC functioning. These relationships are often fraught with conflict, ambiguity, contradictions, and constant change.

Because issues of funding, accountability, planning, and policy are becoming so central to the CMHC director's job, the focus of the dissertation will be on the CMHC director's relationship to and management of this very complex sector of the environment. Both the positive and negative aspects of the role of boundary spanner will be explored in depth. Specifically, there will be a description of the relationships with the federal, state, and local government (including both funding agencies and the legislature), the kinds of problems encountered with them, the positive aspects to the relationship, strategies used in working with the various levels of government, and how relations with the internal organization are affected by the boundary spanner role (see Appendix for the Government Relations Interview
Guide). Emphasis will be placed on strategies and linkages used to manage these relationships and a subjective evaluation of how successful these methods are. The management of this complex system of relationships is to be placed in the context of its historical/developmental roots; and the notion of social support within the CMHC director's network will be examined as a possible mediator of stress and as an aid in accomplishing management tasks.

In summary, questions to be examined in this research include the following:

1. What is the CMHC director's relationship with the federal, state, and local government?
2. What are the major problems encountered with the various governmental agencies?
3. What are the positive aspects within those relationships?
4. What are the CMHC director's strategies in dealing with the various government agencies?
5. Where are the major sources of support within the CMHC director's network?
6. How do relations with the external environment affect relations with the internal organization?

By studying both the CMHC director's relationship to and management of the governmental sector of his/her network, and the stressful and supportive relationships within that network, it will be possible to understand the director's role more comprehensively, his/her management strategies in relation to the various government agencies,
and the sources of stress and support. These findings will add to the literature on mental health administration; have implications for mental health policy; and, perhaps most importantly, suggest ways of training CMHC executive directors so they will do their jobs better (especially in terms of governmental relations), stay in their jobs longer, and be better able to assess stress and develop support.
CHAPTER II

METHODOLOGY

The purpose of this dissertation is to explore CMHC executive directors' relationships with and management of an extensive governmental network, and to delineate their network in terms of stressful and supportive relationships. This is a complex task which requires extensive interviewing of a number of CMHC directors. Because this dissertation explores a topic area which, to this author's knowledge, has not been researched before, and because there is so little literature on community mental health administrators, it was felt that a semi-structured interview format would be the most useful methodology for this project.

Semi-structured interviews were used to allow certain topic areas to be formulated and presented to the directors as a way of facilitating discussion and reaction. McCall and Simmons (1969) suggest that this type of research is ideal for studying the social processes and complex interdependencies within social systems, allowing, for example, a richer, more in-depth understanding of how the director sees his/her role in relating to a very complex network of government agencies, and how s/he ultimately deals with this complexity in order to manage it successfully. By leaving the interview semi-structured, all of the complexity, negotiations, and sources of stress and support were examined and understood.
Since there has been little research on CMHC executive directors' roles in relation to their governmental network and on their sources of stressful and supportive relationships, a major purpose of this dissertation was to begin to explore these areas and add to future research, training, and evaluation. A secondary purpose of this research was to provide a forum for these executive directors to identify and examine some of these issues. Through the interviews they began to define their role in relation to their governmental network and discover sources of stress and support, both within that network and in the more general environment. Discussions of the history of this network and how it was managed may have provided insights into new ways of handling it or affirmed the efficacy of the way it was being dealt with.

In summary, it is felt that the use of a semi-structured interview and questionnaire format is best suited for the purposes of this research and the questions addressed herein. These questions consist of the following:

1. What is the CMHC director's relationship with the federal, state, and local government?
2. What are the major problems encountered with the various governmental agencies?
3. What are the positive aspects within those relationships?
4. What are the CMHC director's strategies in dealing with the various government agencies?
5. Where are the major sources of support within the CMHC director's network?

6. How do relations with the external environment affect relations with the internal organization?

Participants

The participants in this study are nine CMHC executive directors from several states. For the purposes of this research, executive directors are defined as the top executives of an organization having as its primary mandate the provision of community mental health services (Flynn, 1979). The New England region is defined as that area under the jurisdiction of the National Institute of Mental Health (NIMH) Region I office. Included in Region I are Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

The selection of participants for this research was aided by several regional NIMH officials who had expressed an interest in this study. Their familiarity with the geographical area, the issues, and the directors facilitated the progression of this research. Furthermore, their sanction of the study and introductions facilitated entry into a level of hierarchy which might not otherwise have been accessible.

The choice of which CMHC directors to interview was based on a number of variables. Consideration was given to the organizational
structure, location, and funding cycle of the CMHC. Centers have a variety of organizational structures, including being based within a state hospital or other state mental health authority, being based within a county or city mental health system, or consisting of a freestanding, separate corporation. None of these organizational structures excluded a CMHC from being chosen. However, no CMHC was chosen that was affiliated with a medical school because of their typically complicated organizational structure.

Centers were chosen to represent both rural and urban areas. No centers were chosen which were in their first or last year of funding, since that represents too much of an extreme in terms of issues with which the director might be dealing. Directors were chosen so as to include a range of disciplines. Finally, they had all been affiliated with their center for at least two years in some sort of top management position.

Procedure

Once the NIMH project officers identified a potential group of CMHC executive directors, they were contacted, first by their regional project officer, and then by myself. The first contact (by NIMH officials) was a brief one to let the directors know about the study, the project officer's encouragement of it, and to introduce me. I followed that with a letter of introduction, a brief description of the study, and a date that I would call to
see if they were interested in participating. Once they agreed to be interviewed (which they all did), I set up an interview time and briefly interviewed the relevant project officer at NIMH about the specific CMHC so as to be somewhat acquainted with the organization.

At the beginning of the interview I again discussed the purpose of the study, assured the directors of confidentiality, and explained the data analysis and final report. All interviews were tape recorded. The interviews took approximately two to three hours and were arranged to fit into the participant's schedule.

**Interview**

The interview focused on six significant areas concerning the CMHC executive director's relationship with and management of the various government agencies (federal, state, and local): 1. a description of the director's relationship with each government agency (federal, state, and local); 2. a discussion of the major problems encountered with each government agency; 3. a discussion of the major positive aspects of each relationship; 4. a description of strategies used to deal with the agencies currently and in the future; 5. an analysis of the major sources of support within the CMHC director's network; and 6. an examination of relations with the internal organization in regards to the director's role vis-a-vis the government. A structured interview guide was used (see Appendix).
Data Analysis

In analyzing the data I followed methods described by Becker and Geer (1960), Glaser and Strauss (1967), and Lofland (1971). The interviews were transcribed and then read several times so as to become acquainted with the thematic material of each interview and how each interview related to the others. The interviews were then collapsed into topic areas and similarities and differences, as well as general themes, were discussed. Frequency counts of statements were maintained to minimize interpreter bias. In order to maintain confidentiality, only general themes are discussed in the results.

Bias

There are at least two sources of potential bias in this dissertation. The first lies with gaining access to the directors through the NIMH project officers. The second is a result of possible conflict concerning confidentiality. There is, of course, potential bias inherent in introductions through NIMH regional officials. This could result in directors consenting to be interviewed, even though they would rather not, because of the power of NIMH as a funding and accountability source. Bias could also occur within the interview because of a concern on the director's part that information given this researcher could influence NIMH officials either negatively or positively. This bias would most likely occur when
discussing issues surrounding the director's role as it relates to the federal government. A third source of bias could occur if NIMH project officers only pick directors with whom they have a good relationship.

There was little to be done to counteract the first source of bias except to encourage NIMH officials to be aware of this and to perhaps raise this as a problem with the directors. The second was addressed by guaranteeing confidentiality and assuring directors that the researcher has no formal or official affiliation with NIMH. The third source of bias was counteracted by asking NIMH project officers to be aware of this as a potential problem.

Although all directors interviewed were assured of confidentiality, there was still some concern that it would be possible to recognize individual directors based on their answers. This concern was particularly apparent while interviewing them about their strategies and alliances. However, once I agreed to report their answers in a very general fashion, with no specifics or identifying data, they agreed to be open and detailed in their responses.

Summary

In summary, nine CMHC executive directors from several states were interviewed with a semi-structured questionnaire about their relationship to the federal, state, and local government. They
were asked about the components of that network, the problems and positive aspects, sources of stress and support, and their management and maintenance of it.
CHAPTER III
RESULTS - RELATIONS WITH NIMH

In the next four chapters the results of the interview with the nine CMHC executive directors will be presented. The first chapter focuses on relationships with the NIMH; the second on relationships with the federal legislature; the third on relationships with the state; and the fourth, combining two briefer chapters, on relationships with local government and general issues of alliance and support. Strategies used by the directors to deal with these relationships and plan for future viability will be addressed primarily within the context of delineated problems. Examples of director's comments will be used as a way of highlighting the topics discussed. As mentioned in the Preface, it is important to remember that these interviews were done in the spring of 1980, so they do not necessarily reflect the current state of the CMHC movement.

In this chapter the focus of the discussion is on CMHC executive directors' relationships with the NIMH, particularly the regional office. The chapter will be divided into the following five sections: 1. primary contacts at the NIMH, 2. major topics of discussion with NIMH staff, 3. major problems with the NIMH, 4. positive aspects to the NIMH, and 5. a summary.
Primary Contacts

The number of NIMH staff seen as primary contacts by the directors was quite small. Major relationships were with two staff, the project officer and the grant's manager. The majority of contacts were with the project officer around topics to be discussed in the next section. Contact was initiated about equally by both director and project officer and occurred, on the average, about once a month. The majority of interactions were over the phone. Face-to-face contacts occurred primarily at the yearly site visits and grant reviews. In those states where CMHC coalitions existed, contact also occurred at some of the coalition meetings. In addition, informal contact often resulted from regional and national meetings.

The directors' contact with the grant's manager was much less frequent, approximately three or four times a year. Also included in the relationship with the grant's manager were financial staff members of the center. Topics discussed with the grant's manager tended to be specific day-to-day financial matters.

A couple of directors felt it was important to expand the number and frequency of contacts with the NIMH and did this through developing contacts at meetings, inviting people to come to the center as trainers, publishing and reviewing articles, consulting, and sitting on grant review and site visit committees.
One director emphasized the need for developing good working relationships with both the program (project officer) and grant's managers.

I invited the grant's person on the site visit. S/he has been very helpful. We managed to shift some money around and try new programs because of our relationship with him/her. You have to have credibility both with the project officer and the people controlling the bucks. You need to invite them to come visit, see the place.

**Topics of Discussion**

Topics of discussion with the project officers involved a variety of subjects: 1. implementation and monitoring of the federal grants, 2. relations with the state, 3. inter-agency relationships in the area, and 4. congressional relationships, which will be discussed in depth in the next chapter.

**Implementation and monitoring.** A major role of the project officer was that of technical assistance. Thus, many of the discussions revolved around programmatic issues, developmental design, the development of services, staffing issues, organizational development, and grant applications and reviews. All center directors found the project officers very helpful in these areas.

In going through a reorganization we consulted with our project officer at a number of points. S/he reviewed the final report and reviewed the new positions.
S/he is helpful around organizational development, especially with rapid growth. S/he provided some consultants and we went away for a few days. Regardless of contracts and agreements, what is really binding is the personal relationship. I have literally opened up my gut to the project officer. It's risky because s/he's the funding authority and sees your problems, but there is also that trust. I wanted NIMH to broaden their role from monitor to helper. I needed a lot of help with grants and organizational development. NIMH did legitimize consultants and time to go away.

We did get some good technical assistance. We decided to restructure our organization and called in the federal reviewer to get his/her advice. S/he gave us a sense of what others were doing. S/he acted as a technical assistant and it was helpful.

Another important area of discussion with the project officer, and also the grant's manager, concerned fiscal issues. This included developing additional sources of revenue, budgets, federal regulations in relation to financial matters, and planning for the center when it would no longer be receiving federal dollars. The project officer's knowledge of federal regulations and finances was often helpful to the center directors.

We would talk about money, being a graduate center and having to apply for other kinds of money to keep things going. S/he knew what the regulations called for, what had to go into the grant application. S/he would tell me what the concerns of the reviewers were and let me know the decision in terms of dollars and conditions for the grant. The relationship was a thorough and close one.
A final area of discussion was the annual site visit. Most directors and their project officers would develop a strategy for the site visit, including whom to invite and what topics to cover. This planning ahead was to avoid any unpleasant surprises or mix-ups during the actual visit.

Relations with the State. A second major area of discussion was the director's, and if existing, the state CMHC coalition's relationship with the state mental health authority and legislature. This relationship will be discussed in depth in the problem section and in the chapter on relations with the state. Conversations focused on two areas: 1. the interface between the CMHCs and CMHC coalitions and the state, and 2. ways of impacting state legislature relevant to CMHCs, for example, Medicaid. Many of the discussions revolved around developing strategies to influence the state mental health authority or legislature and who would be the best spokesperson (i.e., the center director, the coalition, or the project officer).

We discussed anything that related to the concerns of the CMHC. There were concerns about the direction of the state mental health authority and how the project officer could appropriately impact that. We had some discussions about strategies; how s/he can use his/her official position; how we can work together. The better the state and region can work together and the closer their priorities, the better it is for the CMHCs.
Our project officer was aware of our relationship with the state and the dynamics of the CMHC coalition. We strategized about what I should do and what the coalition should do, where the stuff should come from. For example, Medicaid has a lot of implications for our funding. We decided it should come from the coalition.

Occasionally the project officer sat in on state meetings if it was seen as helpful in furthering the relationship. S/he also "gave advice about the state mental health plan and what is required to meet the CMHC's views and provided information about how other systems work in other states".

Interagency relationships. A third area of discussion with one's project officer was interagency relationships. Federal guidelines require that coordinated services be provided and there is an emphasis on linkages between agencies. Especially in areas where there was an abundance of mental health agencies, the tenor of the relationship was more often competitive and turf oriented than positive and linked. Thus, in order to meet the federal guidelines a strategy had to be developed to facilitate a coordinated relationship.

We had a problem working with this institution, a hospital, and private practitioners. It involved money, politics, and change in the administration, bad relationships, and board involvement. Our project officer has spent a lot of time dealing with that issue. S/he has done it by laying out what NIMH expects, giving his/her own philosophical view of service delivery, putting all this down on paper, and sitting down with the parties.
together and separately. It was helpful because s/he was an objective third party, had power, held the purse strings, and didn't have a vested interest. The others gave him/her credibility.

Problems with NIMH

In identifying problems that had been experienced with the NIMH, five areas emerged. Not surprisingly, finances (including their complexity and lack of clarity, the organization of fiscal affairs/program management, and the issue of demonstration money) was mentioned most. Relations with the regional office concerning philosophy and leadership, staff, and site visits was the second major area. Federal/state relations was the third. Regulations/guidelines was the fourth topic discussed, and career planning was the last.

Finances.

Complexity and lack of clarity. In general, the directors found that fiscal matters were often confusing and excessively time-consuming. For example, one director criticized the lack of clarity concerning spending guidelines.

It's a bit difficult to figure out and get clear cut answers to the financial side. For example, in renovating a building, what's required in terms of federal approval? What's federal and what isn't once it's in the system? What are we free to spend versus the guidelines? Is the remainder of the money after expenses at the end of the year yours to spend? There are different interpretations of the bill. Some centers have gone to court over the issue.
The strategy often used concerning excess money at the end of the year was simply not to have any. Sometimes this was done by making sure all money was spent before the end of the fiscal year. Other centers dealt with the problem by using two corporations, one of which was not subject to federal regulations. This strategy also allowed centers to build up equity, since the second corporation could own property, a strategy increasingly used by centers as a way of becoming financially viable.

Understanding the financial issues was likened to wending one's way through a web while at the same time trying to be creative within its constraints. The project officers were seen as more willing to be creative than the grant's managers. "The project officers have no financial responsibility, whereas grant's management is an auditing firm and not creative."

The general strategy used to cope with the complexity and lack of clarity within the financial arena was to learn as much about the system as possible and to have credibility both with project officers and grants management. This process involved sitting on review boards so that one can see other centers, read their grants, get ideas and meet influential people; understanding the regulations; and getting to know the grant's manager.

Fiscal affairs/program management. A second area of concern was the breakdown between fiscal affairs and program management and the way the financial situation was organized within the NIMH. It was felt there was little coordination between finance and programming at
the regional office. Whereas there are many project officers for a region, there is only one grant's manager, leading to a situation where that person is often overworked.

We made a request in January to change some budget items. We didn't get a response in writing until May, the end of the fiscal year. We did it anyway, but it's not good. I talked to other directors and that's what they do, but if there were a problem and an audit, you know who'd be in trouble. I'm willing to take that risk, but it's not a good way to operate.

The general feeling was there was very little communication between the project officers and the grant's manager. For example, the grant's manager is not involved in developing the grant, only in assessing whether it has been done correctly. Also, s/he rarely goes on site visits. Thus, there is little opportunity to involve the grant's manager in long term planning, leading to a situation where there is a lack of coordination in services and a resultant inability to meet the CMHC's needs. To complicate the picture further, much of the financial negotiations also involved staff in Washington, DC.

The money actually comes from D.C. directly. The fiscal year starts May 1. They didn't know how much money they were going to have, so they approved the grant. We couldn't draw the money until we had a letter saying we were approved for the money, but we couldn't get a letter from the grant's manager until the end of May, so we went one month without money. The regional grant's manager doesn't know anything. S/he says to talk to D.C. We're dealing with three groups, including: a project officer who doesn't know the process either, a grant's
manager who doesn't deal with D.C. well, and D.C. We made one mistake on a fiscal report to D.C. It sat on their desk. They didn't call us. They had to send it back to us and then we had to return it. It couldn't be dealt with over the phone.

A final problem with the fiscal organization was the amount of time needed to make major changes in the grant.

The problem is you need three or four months lead time. You can't operate that way. We have gotten written approval for something three months into the fiscal year. This is where the formal relationship goes to the informal. We go to the project officer and get it OK'd. We totally bypass the formal system.

Whereas the use of informal sanctions could be used to get around the system, no one had figured out a strategy to deal with the split between program and grant's management. However, there were several suggestions, including reorganizing the organizational structure so the two entities would be combined, housing the staff in the same office and requiring the grant's manager to go on site visits.

**Demonstration money.** For all center directors there was a great deal of concern about the future of CMHCs. This concern revolved primarily around the concept of federal funding as demonstration money rather than categorical grants. It was felt that centers would not be able to survive without federal money. This was seen as especially true in regards to staffing and programming for the 12 essential services. Nonreimbursable services such as consultation and education (C and E) and research were felt to be in the most
danger. Because federal money does have an end point, it seems reasonable to assume that the NIMH would feel an obligation to help plan for future financial viability. In fact, the center directors indicated that was not the case. In general, there had been little help from the project officers in planning for the future.

I think NIMH is just beginning to learn what happens to centers as they go off their federal funds. They work with you as if the federal money is going to keep coming.

All NIMH did was to urge us to cultivate third party payments. I already knew I had to do that. They just keep pumping the money in.

In addition to the lack of planning for the future, some directors complained about recurring "screw-ups" with money which impacted additionally on their ability to plan.

They screw up with money a lot. For example, they don't always put in enough money to cover the grants (this year by several million), so the whole system is going to have to pay by not getting monies that were supposed to be there. It's a dumb mistake. We're trying to plan ahead, like with National Health Insurance and efficacy requirements, and it seems like D.C. is just dealing day-to-day. They should be providing some information and leadership.

Just because the NIMH was not as helpful as was wished for in planning for future financial viability did not mean that planning was not occurring. The center directors all had strategies they were using to insure their center's survival. This included phasing
down programs, aggressively pursuing third party and client payments, and documenting center needs so as to encourage the state to support services.

We're phasing it down as federal monies go away. The plan is to finish building the system organizationally, building in a measure of productivity, and looking at it in relation to cost. We'll look at it in a business fashion. Our clients can't go to the private sector, but they can afford to pay something. Also, we'll show the state figures and get them to pick up some. With deinstitutionalization we will need a system of community care which will lead to 100% reimbursement from the state. Funding has to come from multiple sources. The state will be able to fund, in total, emergency services or day treatment and residential, which will replace institutional services. We'll go to other sources for C and E.

Relations with the regional office. Three major areas are covered under this topic: 1. the philosophy and leadership of the regional office, 2. the staff, and 3. site visits.

Philosophy and leadership. In thinking about the regional office and the NIMH as a whole, the center directors voiced concern about overall leadership and advocacy, commitment, and philosophy. Although directors, for the most part, were happy with their individual project officers, they were less happy with the NIMH organization.

The regional office plays a sheep in the herd game. It follows Congress or 5600 Fishers Lane as opposed to advocating in a foresightful way what the mental health system in this region needs. Someone makes a uniform statement in D.C. and it travels all the way down the line, regardless of
its regional consequences... There's not a lot of leadership. It's just turning the cogs in the bureaucracy rather than taking a look at what's needed both in the region and down the road several years.

Questions about commitment were raised concerning advocacy on a policy level of involvement from start to finish of the federal grant.

I'm not sure they always advocate for mental health in terms of legislation. There's no overall support, just support from individuals. The NIMH is not advocating for the centers on a policy level. They're not in my corner, not in a partnership.

Several directors wondered what the relationship with the NIMH would be like once the federal money ran out. There was some concern about whether the NIMH would even be available to the centers at the end of the grant. One suggestion for dealing with the question of NIMH/center relations at the termination of the grant was to hold a series of regional and/or national meetings where this issue would be examined.

One director mentioned problems s/he had had with the NIMH at the beginning of the grant.

The greatest deficits of the feds is that they don't do a lot of preliminary work before you get the grant. They don't arrive until after the money starts flowing. It's a very disruptive time. They could have at least given us leads as to who we could talk to about it. I had to research the whole topic of management change myself, because there was nobody they could lend us for technical assistance. We hired our own outside management
consultant who brought us through... I did talk to some other center directors who had experienced some similar problems. After about eight or twelve months we were hooked up with people for technical assistance by the feds.

Although this director did have a difficult time at the beginning, his/her strategy of hiring a consultant and talking with other center directors proved to be both supportive and efficacious.

The final topic raised in relation to the philosophy of the NIMH was some concern that the CMHC models and goals developed by the NIMH were more appropriate for urban than rural areas. Thus, difficulties arose in implementing the models and complying with regulations.

For example, it was very difficult for some centers to comply with the requirements concerning on-site psychiatrists and psychologists.

Staff. There were numerous complaints about the availability and number of NIMH staff. It was felt that the regional office was seriously understaffed and overworked. The result was unreturned phone calls and a lack of availability. The problem seemed to be the most severe with the grant's manager. S/he in particular was seen as impossible to reach.

We were having trouble with a particular grant we needed to get moving. There was a lot of procrastination. They were inaccessible at grant's management. They were impossible to get in touch with. They don't return phone calls (which is true with the project officer, too).

What I did was to get uptight and send the grant's management person a letter with carbon copies to my congressional people. Hopefully they'll all make phone calls and put on the pressure.
This strategy of working with one's legislators to get something needed by the center was a fairly common practice and will be discussed in more detail in the next two chapters.

There was some feeling, although not pertaining to all project officers, that many of the NIMH staff lacked knowledge and experience. Many directors felt that the demands of the job required expertise in so many areas that it was impossible for any one person to possess all the knowledge needed.

I'm concerned about the lack of knowledge and experience in the regional office. Few regions have people who have come out of the field or have worked in a State Department of Mental Health. Sometimes people who have a tract record of failure end up in regional offices and are assigned a state. I'm not satisfied with the level of competence I've seen around the country. Our region is several cuts above.

In a similar vein, it was questioned whether a project officer would give the same, sometimes risky, advice if s/he were a center director.

I wonder if project officers who have not been directors would be as courageous as they are recommending we be, putting our jobs on the line and standing up to the board.

The final problem mentioned concerning staff was the issue of the project officer as monitor or technical assistant. Clearly, s/he is both, but the role can become confusing at times, both to the center director and the project officer. Questions were raised about how much to trust one's project officer (e.g., what happens if one is treating him/her as a technical assistant and spilling out
problems, but the project officer is seeing him/herself as a monitor) and how to define the role in various situations (e.g., site visits, the phone, grant reviews).

The role of technical assistant and monitor get complicated at times. The relationship with the person becomes important. How far are you going to go? If I didn't think the person had expertise or if I didn't like their style, I would deal with them in a monitoring way. S/he does have expertise and a good style. Initially s/he came in as a monitor to the site visit and I had been dealing with him/her as a technical assistant. We resolved it by defining the roles some and letting him/her know what I thought it did to the organization, their response.

Site visit. Three major concerns were expressed about the site visits. The first was that they are too short for the NIMH staff to fully understand the dilemmas and problems of the center. The second was that the site reviewers change from year to year, which has an impact on feedback about ongoing programs. The third concerned the lack of a relationship between approval of the yearly grant and the site visit process.

A site visit is two days in which to review an organization which has gone topsy turvy. They spent as little as a half an hour with program staff, just throwing out questions without fully understanding. They don't take the time to listen to complete answers. They don't get to the core. They just take surface information. I wanted them to help with organizational structure, but the tone of the visit was much more critical than helpful. The second site visit was better.

What most directors did to combat the problems associated with the brevity of the site visit was to plan it very carefully with the
project officer so as to manage and limit the information flow, make sure the project officer was briefed on the current status of the organization, and maintain contacts with key others in the NIMH bureaucracy so that information was always available in both directions. If the director did not manage the site visit in this manner, the possibility of difficulties increased. This was also true for the grant review process where it was critical for the project officer to understand the grant completely so that s/he could represent the center effectively. Of course the above strategy is more problematic if the center director/project officer relationship is not a positive one.

Some of the directors experienced problems with both site and grant reviews where the reviewers changed from year to year. Not only was there no consistency in view, but the reviews could be somewhat idiosyncratic.

There's a new set of players every year and they tend to take a very personal attitude to the review process. The first year we received high praise for programs developed in the schools. The second year was a different group and we were almost rejected because of the very same programs. The solution was, again, to work closely with one's project officer.

The final problem mentioned concerning site visits was that there was no meaningful relationship between them and the approval of the yearly grant, not did they dovetail in any way. One suggestion was that there should be "a fiscal review and compliance of application every year at the regional office and then have an implementation
site visit where goals are set, etc."

**Federal/State relations.** As will be discussed more extensively in chapter five, the center directors raised many concerns about their relationship with the states. In general, they found the states unsupportive of the CMHC system. This was evidenced primarily in an unwillingness to pick up funding as the federal dollars dried up. The states were seen as wanting the federal money, but also wanting control of that money. Many of the directors' criticisms revolved around state/NIMH relationships. Complaints were voiced about the lack of planning on the part of the NIMH for the replacement of federal money. The directors felt strongly that the NIMH was not doing enough to get the states to support the concept of CMHCs, nor using the power they had to influence the state plans. An example given was of one state where a recent state plan had no mention of CMHCs at all.

NIMH hasn't arm-twisted the states to reflect in their state plans a commitment or a plan. I think they should use their power of rejection with the state plans. They've been taking in garbage as state plans for years. It doesn't even get looked at. It has happened because of a lack of competence in the regional offices and because of the bureaucratic tendency to avoid ruffling feathers. I've seen project officers who've tried to do a responsible job be intimidated by those higher up, including congressional people. They've been transferred, etc. The project officer is responsible for the liaison with the state and the regional office.

The directors felt that the NIMH was overly sensitive to state's rights, often disregarding the long term needs of CMHCs.
There is never conflict between the state and NIMH because NIMH never really has any continuing priorities. They don't want to collide, so they both agree and say they are saying the same thing. The feds are very sensitive to states' rights.

As the directors say it, the unwillingness to engage in conflict resulted in the NIMH not using its power to refuse the state plan when it was unfavorable to CMHCs. They further felt that the NIMH was not doing anything about affecting Medicaid legislation and health insurance, both important elements in the development of multiple financing.

All the center directors felt it was crucial that the states and the NIMH have a positive, coordinated relationship. This was seen as especially important in the future when it was likely that the states would have even more financial control. "The better the state and region can work together, and the closer their priorities, the better it is for the CMHCs."

The center directors felt relatively helpless in influencing state/NIMH relationships. They actively encouraged the NIMH to use its power in refusing unacceptable state plans and sending them back for revision. The directors strategized with their project officers about how to handle state/center relationships. The project officers would also meet with the CMHC councils on a regular basis to help them strategize, and would sit in on state meetings as a way of developing influence. A final strategy was for center directors to interact extensively with the NIMH people and to sit on committees
as a way of influencing that NIMH and encouraging them to develop better, more forceful relationships with the state.

Regulations/guidelines. Two topics were brought up as being problematic in relation to regulations/guidelines. These were budget and proposal timetables and the development of management information systems (MIS). The directors felt that deadlines for proposals and budgets rarely coincided with deadlines established by other funding agencies or community requirements. The result was multiple headaches and masses of required paperwork.

NIMH established timetables that were designed exclusively to meet their requirements and has little relevance to how things need to get done in the community. We have to submit proposals in June for programs that will be starting in November. It's too far in advance. It's designed to give a lot of people time to read the application.

For many centers the development of a MIS system was problematic. In some states MIS systems were developed in conjunction with the state so that there would be a meshing of information systems across centers and state. Other centers were put in the position of having to develop their own MIS system which frequently did not mesh with any other system.

Each center in State X is having to develop its own MIS system. State Y had held from their state and there is a meshing. None of ours will interface with the state. NIMH should be involved in that process and have the capacity to develop prototypes. Why should a center have to develop an MIS out of its 2% monies for research and evaluation. We can't be a change agent for the
federal government.
Rather than feeling that anything substantive could be done about the above problems, the directors seemed resigned to the situation and adapted to it as well as possible.

Career path/training. The center directors were unanimous in feeling that most of them came to their jobs with large gaps in their administrative training and expertise. Because most mental health administrators are initially clinicians, they often lack administrative skills and a community/systemic orientation. Criticisms were voiced about the NIMH's disregard of this problem. Although the NIMH's Staff College does provide training, it was seen as elitist and somewhat inaccessible. Other administrative training was offered, but on a limited basis.

We need more training for directors other than the Staff College. It's a very elitist group. A hell of a lot of resources are going into it and they're only producing about 50 people. What about the rest of us? It should be a requirement that we go away for a three-week session and legitimize it to the board.

An additional problem mentioned was the lack of a career path for center directors. All the directors wondered about what career opportunities were available to them if they left the CMHC fold. One suggestion for a career path/training option was to develop a system where center directors have a rotational assignment with project officers for a few years so that each gets to practice the other's job.
Positive Aspects

Despite the above problems, center directors, overall were quite pleased with their relationship with the NIMH. They found that financial reporting and paperwork requirements were relatively easy to meet. The distribution of federal money directly to the centers was seen as very helpful. The monitoring/site review process was generally experienced as positive and educational.

Working with the feds through NIMH in this region is a pleasure. It's unrestricted, simple and easy to get in touch with the person who can make decisions. Things don't get bounced around. There is autonomy and I can be creative and innovative. There's not a lot of paperwork and red tape. It's person to person rather than form to form.

The monitoring is very positive. Paperwork is reasonable and rational. The system is much more sane than the state's. Monitoring and program reviews are good and helpful with helpful, constructive comments. The critical comments are tied to suggestions on how to improve. They interpret regulations and guidelines for you in dealing with the state. They will send me a letter which I can then use as a backup.

One of the most positive aspects of working with the NIMH was interacting with a few specific project officers. The relationship with these people was one based on problem solving and trust, and because of that was seen as very productive. These particular project officers saw their jobs primarily as one of technical assistance rather than monitoring.
Project officer Y has gone out of his/her way to prove s/he's not a policeman. S/he's there to provide consultation, technical assistance, support, and knowledge about grants, politics, whatever.

I don't feel I have to be on my toes. I can lay out a problem for advice and it won't be used against us. It's an unusual relationship with an auditing function. It has to do with personalities. At the reviews the project officers are clearly battling for their centers.

The center directors generally saw their project officers as part of a team working for the well-being of the center.

What I like most is the informal information, hints as to what's coming down the tube, what the reviewers are seeing in a grant of mine that I have to defend, the feedback afterwards.

The directors also appreciated the NIMH's willingness to evaluate itself and make appropriate changes. This was seen as occurring over the span of the CMHC movement and making it more responsive to changing needs and priorities.

The NIMH did a responsible job of looking at the old staffing grant (what it was doing, what was being missed in terms of priorities, the method of funding), and then moving from five to twelve essential services. They really evaluated the effectiveness of one piece of legislation, identified where it wasn't working, and corrected it.

A final positive aspect to working with the NIMH was the option for training at the Staff College.

The training program for administrators is superb. It brought together organizations at different levels of funding and had a two day working session that developed helpful suggestions and ideas.
Through the training received at the Staff College, directors (and other administrative staff) were in a position to develop contacts with other administrators who could later prove to be an important source of expertise and support.

**Summary**

In summary, the CMHC directors' primary contacts with the NIMH were with their regional project officer and grant's manager. More contact occurred with the project officer than with the grant's manager, but it was felt by the directors that it was important to cultivate good relationships with both. Three major topic areas of discussion with the project officers were mentioned by the directors: 1. implementation and monitoring of the grant, 2. relations with the state, and 3. interagency relations. Problems experienced by the center directors in relating to the NIMH revolved around finances, relations with the regional office, federal/state relations, regulations and guidelines, potential career paths, and lack of training. There were many positive aspects to working with the NIMH including: manageable requirements, distribution of money directly to the centers, a few exceptional project officers who saw their jobs as technical assistance, changes in the NIMH over the years, and the opportunity to train at the Staff College.

Overall strategies used to cope with the NIMH relied primarily on developing a good working relationship with one's project officer. The opportunity to use the project officer as a technical assistant
for organizational issues, site visits, interagency relationships, etc. was seen as invaluable. The development of networks locally, regionally, and nationally was seen as an important strategy in discovering information and developing support. Finally, going to one's federal legislators with particular problems was sometimes seen as helpful.
CHAPTER IV

RESULTS - RELATIONS WITH THE FEDERAL LEGISLATURE

In this chapter the results will focus on the center directors' relationship with the federal legislature. In interviewing the directors about their involvement with the federal government, the relationship with the legislature emerged as an important area to discuss. As has been noted elsewhere in this thesis, the topics and problems outlined by the directors are reflective of spring of 1980, so are not current with today's reality. This is particularly true with this chapter. There are five sections in this chapter: primary contacts, topics of discussion, problems with the federal legislature, strategies, and summary.

Primary Contacts

In relating to the federal legislature, the center directors routinely had contact with three groups of people: 1. individual members of the legislative delegation (i.e., senators and congressmen), usually from the director's state, 2. the legislative aides for the above people, and 3. the staff of various mental health lobbying groups housed in Washington, DC (e.g., the National Council of Community Mental Health Centers and the National Association of Mental Health).

The frequency of contact with the legislators varied depending on their support of mental health and their involvement with key mental health committees. Those who were supportive or sat on key committees
were contacted relatively frequently, depending on current legislation. This contact was both by phone and letter, but "phone calls were always followed up with a letter." Those legislators who were not supportive of mental health were rarely contacted because it was seen as a waste of energy to try to change their minds.

The level of activity with the legislative reps is directly proportional to their involvement in health issues. If they sit on a committee, we may have weekly contact. Both our representatives were in a position to influence health issues. If they don't sit on a committee then it's important to have close contact with their staff in the health area and provide them with information. Their staff can act on behalf of them.

Contact with the legislators was usually through the center directors, although board members were sometimes used if they knew someone who could be helpful.

Contact occurs mostly through the board members because there are several who are highly involved with the political machine. Senator X and the president of the board are very close. If I ever need anything, I just call my board president and get direct contact. We're going after a particular grant which the Senator can help with. I met with an important aid around this grant through the Senator.

The legislative aides were seen as important people to get to know. They tended to be much more accessible than the legislators due to the nature of their job. They were hired by the legislator to advise him/her about specialized areas, in this case mental health. Thus, they were invested in maintaining contact with the CMHC directors and staying abreast of the relevant issues for their state.
I relate to the aides because no delegates from my state are on key committees in D.C. When the legislators vote, it's based on information from the aides. The aides will actively lobby for mental health interests and influence their boss. They are very helpful.

Senator Z's aide is very supportive. S/he provides information, follows through, and works on state stuff, too.

Although there was some contact with the legislative aides who reside in the state, most directors concentrated on developing relationships with the aides in Washington, DC since they were seen as having more power and influence.

Contact with the lobbying groups consisted primarily of receiving information about current legislation, its impact on mental health, and suggestions as to what to do about it. Contact also revolved around position statements and legislative or yearly meetings. This topic will be further discussed in the strategy section.

Topics of Discussion

Topics discussed with the legislators and aides fell into two areas: 1. current and future legislation and 2. day-to-day activities of the center. The directors felt it was important for them to be knowledgeable and to exert pressure about any legislation that would impede or enhance their ability to provide mental health services to the community. Much of this influence was exerted through the various lobbying groups, but the directors felt it was important for them to do this individually as well.
Examples of specific legislation that was of concern at that time were the following: the Mental Health Systems Act, Medicare and Medicaid, National Health Insurance, and Title XX. All of the above had a significant potential for impacting on mental health services, even if indirectly.

Welfare is very reliant on Title XX and we need the use of their services. We have been urging the aides to take some action on Title XX. We helped build a coalition around this issue in the community. I have a close working relationship with the state people on this.

The Mental Health Systems Act was critical because it was the new enabling legislation for CMHCs. Without it, the future of CMHCs would be seriously endangered. Thus, it was critical for the CMHC directors to develop an effective lobby which would aid in getting the Act passed. Medicare and National Health Insurance are examples of legislation where it was important to influence the process so as to be included financially within their guidelines.

Examples of legislation we are working on now are: 1. the Act and where it is (we're trying to get the Senators to press for it to come to the floor); 2. Medicare amendments which need to include the provision of CMHCs having provider status; and 3. National Health Insurance, which is a key issue for community mental health. There is no definition of a mental health clinic. Without it we're dead. They probably will put firm shackles on it. We need to make sure we get in. I can imagine the day when it will be fee for service rather than a grant... It's a continual battle for us to be covered by legislation and not to be excluded financially.

Concerning day-to-day activities of the center, three topic areas were discussed with the legislators. On an occasional basis requests
for a speaker were made to particular legislators. They were also times when a center director would let his/her delegate know about the center's dissatisfaction with state/federal interactions. More commonly, directors went to their legislators around grants they had either received and were having trouble with or grants for which they were applying.

I'm having trouble getting money that was approved ten months ago. I'm about to write a letter asking my representatives to find out what the hold up is and to push it along.

. . . .

I'll get in touch with my representatives about grants which are approved but unfunded. I can call and say we don't have any alcoholism money coming into the state. I'll give him/her that information, especially if it's not his/her area of expertise. It will make him/her look good. In this case I will talk to the Senator when s/he comes to the state. It can be very helpful if it's a highly competitive area and they have some vested interest in it, for example, they're on some committee and it will make them look good.

. . . .

Once we were approved but not funded, I met with the aide and gave him/her a copy of our grant. I kept him/her informed. When funding delays began to occur they began to make inquiries about the status of the funding. We already had the information, but their continuous questioning kept up a consciousness. The legislators have been quite supportive.

In addition to the legislators being supportive around current and future grants, they also were helpful in providing information about funding issues.
I was worried about budget cuts so I got in touch with my congressman, my project officer, the National Council of Community Mental Health Centers, and the legislative aide. I finally tracked down the information through everyone to find out that my budget would be OK.

Problems with the Federal Legislature

The problems experienced by the center directors with the federal legislature were not specific ones, as much as they consisted of a general feeling of powerlessness, lack of influence, and being low on the priority list of national issues. The directors felt there was a lack of interest in mental health on the delegates part. If they were not on a mental health committee, they were seen as not having enough time to be familiar with the issues.

At the senate level, we're in a different situation. We have two senators who are so opposed that they negate each other. One is anti-social programs, so we don't even work with him/her. We just cross him/her off. The other is more supportive, but there's a political inconsistency. Another representative will support and lobby for issues and research for the state and the constituents. S/he's more apt to vote along political lines. S/he's not as helpful in passing legislation, but in advocating for it once it's passed. S/he gets the wheels unstuck.

Another complaint was that there was never any feedback on the directors' education attempts.

The problem is mostly with follow-through. I never know if they do anything with all the information I give them. Mental health is pretty far down on the priority list. People don't want to deal with the problem. I spend a lot of time educating people.
A final concern was the impact of national political struggles on the welfare of mental health, specifically the Mental Health Systems Act.

The biggest problem at the national level is their confusion about community mental health legislation. It's an incredibly complex political situation. The Act has gotten caught up with Kennedy/Carter politics and they've botched it up. We have a current CMHC act that is here only to the end of the year. It's now on renewal for a year while the new act is being passed. It probably won't be passed. The problem is what the legislation will be for 1982. The Systems Act is hung. There are lots of different versions (e.g., funding through states or local areas). It's the only funding source now that doesn't cause us problems because it comes directly to us. Giving the money to the state would be a disaster.

**Strategies**

The center directors detailed a number of strategies they used in coping with rapidly changing legislation, sometimes disinterested or uninformed legislators, and the need to develop an effective CMHC lobby. They relied extensively on various lobbying groups for information, lobbying, and the development of a sympathetic and helpful network.

The National Association of Mental Health, the National Council for Community Mental Health Centers, and the National Association of Social Workers all pay attention to a lot of pieces of legislation. It's important for me to know this stuff. The groups are helpful. They are accurate, brief, and concise about what the issues are. They distill information, give the background, and what they want you to do about it on a page. Over time you get a sense of the evolution and how things fit in.
Although there was some criticism of the National Council of CMHCs for being poorly organized as a legislative network, the directors relied heavily on their legislative information, examination on issues and implications, positions, and form letters. They were seen as quite successful in their work with other groups on the Mental Health Systems Act.

I think they have been effective with the Systems Act. They formed a good coalition with NAMH and the National Association of Mental Health Directors. They did their homework and got agreement. They compromised. They managed to see the total picture and what needed to be rescued. The state directors and unions wanted a tremendous amount of state control to protect jobs and institutions.

The National Association of Mental Health (NAMH) was mentioned as a particularly effective lobbying group. They were seen as having a good way of getting information out to people (the Public Affairs Information alerts - PAIs) and responding quickly to legislative issues. The PAIs highlight current issues, tell people what to do and whom to contact, and have a feedback system.

The directors tried to have frequent contact with the legislative aides who were seen to be quite influential and relatively constant through changes in administration. Contact with legislators was also maximized.

For both aides and legislators, education about issues and their impact on mental health in each director's center or state was seen as crucial. Education occurred through a variety of means. One strategy was to have constant contact around a particular piece of legislation.
I tell them about the piece of legislation and what I want them to do about it. That includes the dollar amount and the consequences for this center and the state. I ask them to take a specific position. On key pieces of legislation people have usually come through with the vote. I try to keep them posted on critical times for the piece.

Another frequently used technique was to provide important and perhaps inaccessible information to federal delegates or committees.

We were concerned that funding priorities were shifting toward urban centers. NIMH provided us with this information. They can't lobby, but we can pass the information on to the legislature.

Our state center director developed a position statement prior to a state meeting. We sent a copy to the National Council of CMHCs and it was used in senate testimony about how bad the state system was and why money shouldn't come through the state.

The last strategy used to educate legislators and their aides was to invite them to the center for public events like the annual dinner or a building opening. The assumption was that the delegate would feel more a part of the center and would also appreciate the public exposure to his/her constituents.

It's important to know the staff both in DC and in the state. I always invite the staff in the state to meetings. It sensitizes them to our organization, problems, and issues. It gives them a context when I have to go to them with a request. They come to our meetings. A year ago we had a congressional day where we invited staff, senators and representatives to visit. It was not well turned out, but it has eliminated the perception that we were not to be accountable. It took a lot of initiative and created a lot of guilt, which we used in follow-up
contact with them when they raised questions about the budget. I told them we had gone over that in the meeting. The focus was primarily on funding. We went over with them the implications of losing our federal money. It sets the stage for our need for state and federal funding.

A final strategy used in influencing legislation, senators and congressmen was to develop an extensive network of contacts at the state and federal level. This was accomplished primarily through sitting on committees and task forces, using contacts from their prior jobs, publishing in the relevant literature, and holding liaison roles.

I have a friend in the legislature. I use that relationship whenever I can. S/he's involved in the presidential campaign... I have spent many years cultivating relationships at NIMH to gain visibility and entry.

The National Council of CMHCs was often helpful in this endeavor by holding meetings for the center directors with the legislators. Not only did the center directors use their own carefully cultivated set of contacts, but they also used their board members' contacts. This was an important source of influence and used frequently.

Summary

In summary, the center directors' primary contacts were with those federal legislators from their state who were at least somewhat supportive of mental health, their staff aides, and various mental health lobbying groups in Washington, DC. Frequency of contact depended, to some extent, on current legislation or center problems. Topics of discussion revolved around current and future legislation and day-to-day
activities of the center. Few specific problems were experienced. Rather, concerns were about the lack of national interest in mental health and the CMHC's lack of influence. The directors found it frustrating not to receive feedback and were concerned about the impact on mental health of national political struggles. The strategies used to influence legislation and build ties with the legislators were varied. They included using the mental health lobby groups for information and influence, having frequent contact with the legislative aides, educating both aides and legislators about issues, providing exposure for the delegates, and building and using a network of contacts (including those contacts developed by board members).
CHAPTER V
RESULTS - RELATIONS WITH THE STATES

In this chapter we will examine the center directors' relationships with the state, specifically the state mental health authority and, to some extent, the legislature. The states in which the interviews occurred differed dramatically as to organizational structure, philosophy, organization and power of the state mental health authority, support for community mental health, and number of competing mental health agencies. Many of the center directors were quite concerned about the maintenance of confidentiality, especially in relation to the state and the strategies they were using to influence that relationship. Thus, this chapter will be written so as to make sure confidentiality is maintained. The result will be a loss of specifics as to organizational structure and other details which might identify a particular state or director. However, the presentation of results and the examples used will convey the flavor of what the directors discussed. This chapter will consist of five sections: 1. primary contacts, 2. topics of discussion, 3. problems with the state, 4. strategies, and 5. summary.

Primary Contacts

The number and type of contacts the center directors had to maintain within the state were quite different from the situation
with the NIMH and the federal legislature. The major difference was one of numbers, they were simply more people to relate to, both within the state mental health authority and the legislature. In addition, there was often no central figure who was in a coordinating position like that of the NIMH project officer, or, if there was, s/he rarely held similar decision making power. Because of the high turnover in state government, the contacts also tended to change relatively frequently.

Depending on the organization of the state mental health authority, center directors had more or less access to various levels of bureaucracy. Those states where the authority was smaller and less bureaucratic, afforded the directors more contact with various levels, including the commissioner. In this situation directors had more choice about who they wanted to work with.

My contact is primarily with Mr. A. I know him well, so I'll work with him since we get along well.

Ms. B. is a key person as much because of the person as the position. She's easy to work with. I focus on who is easy to work with. We make deals about who we will work with.

Other states were more bureaucratized and rigid as to whom the directors could have contact with. Most directors did have some sort of regional or specialized contact, although it was often unclear how much decision-making power that person had. Contact with the state mental health authority was frequent and initiated by both parties.
Topics of Discussion

Topic areas discussed with the state authorities focused primarily on four areas: 1. funding, 3. policy and program development, 3. the chronically mentally ill, and 4. legislation. According to the directors, a large proportion of the conversations centered on funding related issues (e.g., proposals, contracts, data required for justifying budgets, and budgets).

Ninety-nine percent of our conversation is funding. We discuss accountability data in terms of number of clients served. We have to give it to the state and it will determine next year's budget.

Discussions of policy and program development covered a number of areas that had potential impact on CMHCs. These included the state plan, state goals and objectives, the development of standards, department regulations and guidelines, and other community agencies.

We discuss systemic and developmental issues (e.g., emergency services as a systemic service) and other agencies and how they are relating to me.

A significant portion of policy and program development discussions revolved around the chronically mentally ill and coordination between hospital and community.

We spend time on new laws that have been passed which have to do with case management of patients from the hospital to the CMHC and the development of procedural guidelines for that process. A committee was set up to look at that specifically.

Legislation topics, too, centered on funding, policy, and the chronically mentally ill. Included were patients rights, Medicaid
legislation, and other bills which had the potential for impacting CMHCs. In those states where CMHC coalitions existed, concerns about legislation, both with the state mental health authority and with the legislature, tended to be taken care of by the coalitions. CMHC coalitions will be discussed later in this chapter.

Problems with the States

Those problems with the states which were mentioned by the center directors fell into six categories: 1. the bureaucratic nature of the state mental health authority, 2. funding, 3. no support for CMHCs and an emphasis on the chronically mentally ill, 4. state staff, 5. acquisition of power, and 6. state/federal regulations.

Bureaucratized state systems. To the center directors, the most problematic aspect of dealing with the states was the massive bureaucracy that had to be negotiated. The directors thought the state systems were "too bureaucratic and monolithic, disorganized, and poorly managed and structured." Specific complaints centered on: 1. too much paperwork; 2. time frames for proposals, budgets, etc. which did not mesh with any other reporting requirements; 3. an emphasis on units of service rather than quality; and 4. difficulties in changing aspects of contracts.

Contracts have to be developed well in advance of implementation. There may need to be changes. If so, you have to go all over the place to do it. It's a bureaucratic nightmare to get a simple thing changed (e.g., a position changed from social worker to nurse). The NIMH takes hours; the state mental health authority takes months.
A recurring difficulty for the center directors was their lack of information and understanding about what was going on within the state system and lack of knowledge about who the key people were within the state. Often it was difficult to figure out who to go to if there were problems.

Making decisions is difficult. It's hard trying to know what's going on, who the key actors are, and making sure we have a role in it all.

... .

There's a pecking order we're supposed to follow, and a decision-making level. The question is: where does something have to go for a decision to be made? It's like shoving it into a hole (one of those department store pneumatic tubes) and hoping it comes back. If I don't get what I want, I don't know who to go to. With the NIMH I go to my project officer.

The directors dealt with this problem primarily through network building and developing individual relationships with people in the state as a way of gaining access to information and developing contacts and influence.

Mostly I talk with people. I know most everybody. It's a very close network. Relationships have come with working with people over the years. I have a good reputation. People trust me. I'm honest.

The directors felt that one of the more significant problems confronting them within the state was the general chaos of the bureaucracy and the lack of future planning, direction, leadership, and setting of policy. What planning did occur, did not always include CMHCs.

The problem is lack of direction and lack of leadership. There are few funding authorities within the state who give a damn about mental health.
They throw the scraps off the table and we all claw at it. We provide most of the services. It's kind of frustrating. We are now beginning to serve on various selection committees, but generally feel pretty much abandoned.

.......

We talk about day-to-day policy problems, but I don't feel a sense of direction, short or long term. It's hard to do planning when we're losing all this money.

Strategies used to combat these problems relied heavily on CMHC coalitions, network building, gaining influence through sitting on committees and task forces, and using the state legislature. These strategies will be discussed in more depth in a later section of this chapter.

**Funding.** Fiscal stability and the planning for it was of concern to the center directors. They all felt in a squeeze between decreasing federal money and the differing priorities and limited money within the state. Overall, the directors thought there was not enough money to support CMHCs within the states. On the state level there seemed to be continuing disagreement about the necessary amount of funding needed for CMHCs and how to distribute it equitably among them. Just as there was little policy or program planning on the state level, there was also inadequate financial planning.

Fiscal stability is the key. In its absence you don't have any time to put into quality care. We're reactive instead of proactive. Long term program development does not happen. Ninety percent of our meetings are crisis oriented. If we had a good financial plan we'd put less of our psychic energy into all this crap and put more energy into
making the system go. We're immobilized in terms of planning because of not knowing what our budget is going to be.

Those states that had CMHC coalitions did have plans to work with the state mental health authority and legislature to look at various options and plan for the future. One suggestion was to organize a task force which would develop funding principles that would have dollar amounts tied to them.

Of final concern for directors were those states where funding was based on a reimbursement model. This financial arrangement created real hardships in the beginning phases of a program, since it often took several months to be reimbursed for money already spent. Serious cash flow problems resulted and the centers were often perceived as poor money managers by the surrounding community.

Starting a program is a real problem. We have few assets (since we are non-profit) to secure loans with banks, but to put the program on line we have to find money for about 60 days until they reimburse us.

Non-support for CMHCs. The feeling that there was a lack of support for CMHCs within the states dovetails with the concerns expressed about funding, but is broader ranging and covers policy, philosophy, and issues of control. In general, the CMHC directors saw little support within their state for community mental health services or CMHCs. Instead, they saw the main focus as being on the chronically mentally ill, with a disproportionate amount of the funding going to mental hospitals.
They're not just interested in funding a full range of services, just chronic and acute. Their priority is deinstitutionalization. This will lead to outpatient and consultation and education services being in jeopardy as federal funds dry up. The state doesn't take a comprehensive view.

State/federal priorities are now different. The director of the state mental health authority does not support comprehensive mental health services. S/he wouldn't mandate the five essential services, but rather focuses on chronic patients. I think s/he would want to put mental health centers out of business and instead go to the private sector for acute care and the public sector for chronic care.

Based on the above priorities and future trends in funding, the directors were very concerned about how to minimize the states' control of the situation and maximize their own. Numerous strategies were developed to address this problem. The development of a state CMHC coalition was a principle one, which was designed to establish an influential, supportive network statewide. A second strategy was to work primarily with those who were supportive of community mental health and to give them support. A third technique was to use the NIMH's power to veto the state plan. However, this was a double-edged sword, in that vetoing the state plan would also cut off money to the CMHCs. A fourth tactic to gain influence and educate people about CMHCs was to sit on various committees and task forces. This also led to increased exposure and collection of information. Finally, the center directors continually advised the legislature as to their funding needs.
Staff. Many concerns were voiced about the competency of state staff and the high turnover rate among them. The center directors felt there were few good people to work with, either because of their lack of skill or because of lack of continuity due to turnover. The directors tried to rectify this situation by gaining some influence over state appointments, getting on search committees, and doing informal negotiating. If worse came to worse, they would occasionally refuse to work with a person who they felt was particularly incompetent or difficult. "Three of us have refused to work with one person we feel is incompetent."

In some cases, a major problem existed for center directors where state workers were employed within the CMHCs. Although they worked side-by-side with CMHC employees, the center directors had no authority over them. The state employees were under different pay and personnel policies and were hired or fired by the state, not the center director. The directors felt this led to a great deal of internal tension within the organization.

There is a tremendous infiltration of state employees into agencies leading to the agencies being quasi-state. State employees should not be employed in private agencies. It becomes an employee management problem (i.e., different personnel policies and pay).

Power. Many of the concerns expressed by the center directors revolved around issues of power and control. The state system was a very politicized environment with a varying and extensive case of characters. In those states that had smaller and less well developed mental
health authorities, more comprehensive systems of CMHCs, and fewer competing mental health agencies, the CMHCs tended to have more power and influence.

The state doesn't do program development or policy making. We do it all. The CMHCs have become the policy making group for mental health. The state should be setting policy, but they don't have the staff, the competence, or the time.

We agree on treating people in the community. We don't agree on the independence of CMHCs. The question of control is a live one. It's a control battle. I'm not sure they know what they want. There's not one thing called a state. It's a collection of people who formulate policies, bend to political pressure, and are swayed by argument. They don't have power to implement what they want except in an atmosphere of cooperation. The CMHCs got power because of the way they were originally set up and the organization of this state... Rules and regulations have to be developed with others outside of the state mental health authority because it's small. There's much more sensitivity to external thought. When it's working at its best, it's a partnership between the CMHCs and the state. It tends to go back and forth between a partnership and an adversary. There are disagreements about control.

Many of the directors' reasons for wanting to influence mental health in the states had to do with concern about the chaotic nature of the state, especially in relation to state staff turnover and competence, and funding. In addition, the directors were worried about the philosophical view of the states (i.e., more emphasis on the chronically mentally ill, rather than comprehensive community mental health). This led the directors to develop several strategies which would increase their power and influence. Coalition and network building were primary
techniques, as was sitting on joint committees.

I sit on lots of joint committees (e.g., discharge plans from the state hospital, standards for CMHCs, patient rights, services to children, the state plan for CMHCs). Most of the time it works. There are still conflicts about the amount of necessary funding and what it should go for. They have not committed themselves to support CMHCs. They don't want to deal with it. We're working on this through a legislative committee.

**Federal/State Regulations.** This topic has been discussed extensively in the chapter on relations with the NIMH. However, many of the directors reiterated the problem in discussing the state and expressed their concern about its implications, especially in the future.

The state needs to develop a parallel system to the NIMH, with project officers. That way we don't have to deal with site visits one month from the state and one month from the feds. There is little interaction between the state and the feds because the vehicle for funding by-passed that relationship. The NIMH money comes directly to us. There is a lack of state responsiveness to the NIMH. There were a number of years where the state representative did not go to the review meeting to support our application. This has changed due to influence by the regional office. It grew out of a refusal to approve the state plan.

**Strategies**

Strategies used by the center directors to gain influence and control, and to make their centers more viable, fell into several categories. Included was network building, circumventing or fighting the system, developing CMHC coalitions, and influencing the state legislature.
The long term strategies used by most directors in dealing with the vicissitudes of the state involved building a good organization, generating data, developing multiple funding sources, and building coalitions in order to get power. "By yourself, you're at the mercy of all the funding sources." All the directors felt it was imperative to establish fiscal stability. In its absence there was no time to implement quality care; instead the directors became reactive rather than proactive.

Network building. Network building within the community was seen as a way of gaining support, ideas, feedback, information, and power. This was accomplished by working with many people, serving on committees (which often gave access to influential people); developing alliances with state and federal legislators, the governor, and other powerful people; and getting appointed to state selection committees.

My role on a high level state committee is very important. It's responsible, by statute, for developing a philosophy, goals, and objectives for the system. I have a chance to have substantial influence. There are other directors on this committee. The group is sensitive to community mental health. There is ample opportunity to influence. It's a high priority for me now. It's the only means I have of holding the state leadership accountable. I can raise questions there that I could never raise as a center director. They work for us. I use it to ask questions and ensure that they are aware of what's going on. It keeps the state honest. I can communicate expectations and I will make sure the issue of priorities comes up.

On a local level, many of the directors helped develop agency coalitions that could act as a united front in dealing with the state.
Agencies in this area have developed a vendor association. We meet regularly. We have become a counterforce to the state. We can establish criteria for RFP's and new programs. We can decide among ourselves who should get it. We have developed trust by being trustworthy. It used to be cutthroat competition. Now, we meet two or three times a month. The vendor association is a lobbying group, impacts budget requests, and lobbies against the state. We are in the process of forming a mental health system which will have data and power.

CMHC board members were used extensively by the center directors as a way of gaining access to influential people and establishing a high level of participation in the workings of the state. As with the center directors, there was an attempt to get board members on as many committees as possible. Board members were especially helpful in acting as the political arm of the center. This allowed access to many more state representatives, with a resultant increase in the flow of information and lobbying around particular legislation. "Bringing the boards into the process has really helped influence the legislature." Another advantage to involving the board members in the dealings with the state was that the center directors did not get focused on as the exclusive troublemakers within the state. Not only was there more power in numbers, but it was also more difficult to single out individuals to punish.

We are now actively encouraging the board to be involved. It's an opportunity for them to take an active role in the proceedings. It also spreads the heat out a bit so it doesn't all get focused on the directors.
Fighting the systems. Circumventing or fighting the state system was another tactic routinely used by the center directors. This included vetoing the state plan through the NIMH, making decisions to do something despite the state's wishes, all centers or agencies refusing to sign undesirable contracts and refusing to work with incompetent state people.

In the last contracts there were clauses that gave them unlimited access to records and allowed them to cut funding but require us to provide the same services. We, as a group, refused to sign the contract and requested a meeting with the director. The board presidents were brought in on this as well, making it more formalized.

.......

We find out ways to circumvent the system. We go ahead and do things. It's easier to seek forgiveness than to get permission... There's a yearly contract that has to be signed. It's outdated so we decide not to sign it. We're an ad hoc group of clinics. It's made up of directors and board presidents. We came together to express our opposition to the agreement. We sent letters with signatures. That led to a meeting with those who could do something about the situation.

.......

All clinics in the consortium are bound by rules about revenue retention. We have to spend the money according to a list of priorities. Screw the priorities. We need to spend the money to run the show. We've made a decision to go ahead and spend the money without asking.

Coalition building. Developing coalitions of CMHCs was a major priority for all the center directors. The coalitions basically grew out of a
concern for CMHC/state relationships, the availability and distribution of funding, and the development of community mental health services in the state. The coalitions were established to meet a variety of goals, including the following: 1. lobbying with the state and federal legislature, 2. developing policy, 3. providing a united front and leadership in community mental health, 4. working on issues of funding, 5. creating a clearing house for needs and expertise and a forum for exchange of information, 6. developing common strategies around major issues and problems, and 7. generally dealing with anything that was perceived as an opportunity or threat.

The goals of the coalition are to provide a forum for directors and board presidents to exchange information and to develop common strategies around major issues and problems that affect all of us. Basically, we are an advocacy group. We do a lot of lobbying within the state. The executive director of the coalition is representing the center in Medicaid negotiations.

The goals of our coalition are: 1. to arrange for staff and board development, 2. to negotiate for CMHCs with Medicare, Medicaid, Blue Cross, and the state, 3. to provide for communication between centers and outside sources, and 4. to be active in designing mental health systems for the state and to be involved in formulating and affecting legislation. Board members will do much of this by being assigned to state and federal representatives. Usually we respond to specific legislation, the budget, or things like National Health Insurance and Medicaid. We have hired staff for the coalition. The actual contacting of the legislature may be done by board members, but the background work is done by the staff. The board people will make the public statements. We have had an impact. The legislature has turned
to the coalition for help on the budget and funding decisions. Its influence on federal stuff will be as a subgroup of the National Council.

In those states where CMHC coalitions existed, much of the interaction with the state was through the coalition. This was helpful in a number of ways. There were staff to develop relations and lobby with the legislature and as a group, they could also introduce their own legislation.

The staff of the coalition keeps track of what's coming up in the legislature; plus, we will introduce our own bills through a friendly legislator. We need to assess who's against us, too. The coalition would not take a stand on elections. It can't afford to get too political, rather, we'll sway people in the legislature.

Because the CMHCs were grouped together as a coalition, there was more power to address state-wide issues without the fear of being singled-out and punished.

The CMHCs have developed an association. Individual centers are committed to that group. We want to make it strong. When we have a political confrontation that affects all of us we do it through the association, otherwise the coalition would be by-passed. We relate to the state around planning, legislation, policy-making, and philosophy... If they want to deal with the centers around certain issues they have to go through the coalition. We had some conflicts with the state and also among the centers. We started to deal with the conflicts and got together a coalition. Now we're in unity more than we're apart. Before the state could work with individual centers. We felt the 80's were not a time to be separate. We're all going after the same scarce bucks. We better get a forum where we can compromise.
The power of the coalition was also relevant in situations where the group decided to fight the system.

One of the directors read the contract and picked up issues that were of concern. S/he got in touch with everybody else. We decided not to sign it.

The directors found the coalitions particularly helpful in areas that were advantageous to all the centers (e.g., negotiating contracts).

Those areas of financial support that are not competitive and are advantageous to all of us, we've done a good job in (e.g., legislation requiring health insurance to cover mental health). The coalition has a negotiating team that goes to Blue Cross and Medicaid to negotiate contracts. In these areas the coalition is really getting strong.

Whereas the center directors were generally critical of the NIMH's relationship with the states, they were quite positive about the NIMH's involvement in establishing the state coalitions.

The feds were very helpful in setting up the coalition. They gave advice and support. They routed all the training money through the coalition rather than the state. They also found applicants for the position of executive director of the coalition.

Influencing the state legislature. Although most involvement with the state legislature was through the CMHC coalitions or state associations, such as the Association for Mental Health, the center directors felt it was important to develop individual relationships with the representatives as well. Most of the network building was done with the representatives from the director's area.
My primary relationship is with the legislator from this region. I see these people all the time; they're involved in everything. I'm paid to cultivate these relationships. I do it socially, through neighbors, and making sure I meet with them professionally.

Lobbying focused on the budget and legislation. Influence attempts came from both the board and the center directors. "When the legislature convenes and bills are being considered, I let the legislators know I'm available to answer any questions. Some take advantage of the offer."

Just as the National Council of CMHCs and the National Association developed position papers and lobbying strategies about national legislation, the comparable state organizations did the same. This proved particularly helpful as an aid in educating the community and the board about issues relevant to community mental health.

Positive Aspects

Unlike relations with the NIMH, there were very few positive comments made by the directors about the state. Those comments that were positive concerned individual people rather than the system.

In those states that were smaller, more rural, and had less developed state mental health authorities, positive comments were voiced in reference to the power and influence of the CMHCs in those states.
The relationship is informal. It relies on the CMHCs' honesty. Most of the time it's pleasant. On most major issues there is support. I wouldn't trade it for a larger system. It doesn't have standards and regulations well developed. We'll keep from doing it by making proposals... A small, informal network is a source of important information. It's also distinctly advantageous in terms of getting work done.

This small, informal network allowed people to know each other as joggers, tenants, and grocery shoppers, rather than just mental health professionals, state bureaucrats, and legislators. The result was often a more cooperative working relationship.

Summary

In summary, the center directors' primary contacts were with a larger number of people, who were changing jobs more frequently and had less authority than at the NIMH. Topics discussed focused primarily on funding, but also included policy and program development, the chronically mentally ill, and legislation. Problems with the state centered on the bureaucratic nature of the state mental health authority, funding, lack of support for CMHCs and an emphasis on the chronically mentally ill, state staff, acquiring power, and state/federal relations. Strategies used by the center directors in dealing with state problems included: network building, coordination with other agencies, use of board members, circumventing or fighting the system, developing CMHC coalitions, and influencing the state legislature. Long-term strategies emphasized fiscal stability, the generation of data, and power acquisition. The two
positive aspects mentioned in working with the state were individual relationships and working in a state that was small, informal, and did not have a well-organized mental health authority.
CHAPTER VI

RESULTS - RELATIONS WITH LOCAL GOVERNMENT AND PERSONAL ALLIANCES/SUPPORT

In this chapter two areas will be explored. The first section will examine center directors' relationships with local government (i.e., towns, cities, and counties) and the second section will look at their personal source of alliances and support.

Relations with Local Government

The amount of financial support received from local government by the CMHCs was quite small in comparison to that received from federal, state, and third party payments. The amount ranged from 4-10% of the total budget, with dollar amounts ranging from $40,000 to $100,000. This relatively small amount of money, however, did not mean that the directors had minimal contact with local government. In fact, it was just the opposite; local government required a great deal of time in terms of accountability and information.

Our budget breaks down to: 30% federal, 30% state, 25% fee for service, and 8% local. We get 80¢/capita. They're very supportive, but they're very poor so it's a real drain. We've worked very hard to cultivate a good relationship with the local political folks.

The number of people who needed to be related to, the frequency of contact, and the amount of political maneuvering has increased as this research has moved from national to local government. The center directors (especially those in rural areas) had to relate to
a large number of people, including town, city, and county councils, other local government officials, and area representatives.

**Topics and Problems.** Topics of conversation revolved around information sharing (especially concerning the center), service delivery, and funding. There were four major problems experienced by the center directors in working with local government. The first was the pervasive view by local people that CMHCs were "fat cats" and did not need additional revenues. This was often aggravated by smaller, local mental health agencies who were threatened by the power and influence of the larger CMHC and were afraid they would lose their resources to this "monster" or be "gobbled-up" by it.

> They think we're really rich because we're the biggest agency around. They don't want to give up money and they're upset about my salary."

This problem was primarily dealt with by continually emphasizing what services were being provided to the community, informing local government of the implications of an absence of CMHC services, and using board members as influence agents.

> I tell them the implications and I get board members to put on the heat. I have to give them very concrete examples of services we provide. It's the same kind of message you give to Congress. They need a case to visualize.

A second problem experienced by the directors was the enormous amount of accountability and expectations of service in relation to the dollar amount received.

> A community that gives us $50/year expects a lot of accountability. They expect us to
provide for their needs if they have given us money.

A third problem concerned expectations about deinstitutionalization. Many of the local people were just as happy with the chronically mentally ill placed away from their communities. This view led to conflicts when the CMHC pursued its mandate to provide services to the chronically mentally ill within their own community. This conflict was particularly intense in relation to community residences. The strategies used by the directors to address the above two problems was a great deal of negotiation and information sharing.

The final problem involved personality clashes or difficulties in working with those who were anti-human service. The major strategy here was to work around these people and develop relations with those who were more supportive.

Strategies. The center directors felt it was important to develop good relationships with local government, not only for funding purposes, but because the communities were where the CMHC services were delivered. Working with local government provided an "opportunity for sharing who we are and what we do, and takes away the mystique and the stigma." In order to accomplish this goal the directors had developed a number of strategies which were aimed at developing good relationships with the communities and local government.

A primary strategy was the extensive use of data, case examples,
and publicity so as to educate the community about services provided and clients served.

I go to town council meetings and present how many people in the town have been served and how many units have been delivered. We have fairly solid figures. I talk about cost and reimbursement. I present to the town that they should help with deficit funding. I recruit the client population and board members to appear before the town.

* * * *

The services that we provide are the things that get us money. We do a tremendous amount of community education and lots of advertising of services. Our emergency services program does a lot. It works with the police and directly affects the population of the town. We are there for emergencies. We use the press a lot. We also hit the population that wouldn't normally come to the center (e.g., offering a money management program).

A tactic used by many directors was to go to city and town meetings (both general and special committee) and present data about the center's services, ask for feedback, and bring client and board advocates. This was seen as an opportunity for information sharing and rarely were funds asked for at that point.

We are now starting a new approach. We're going to all the towns and lobbying for money. It won't provide much increase in money, but it will get town officials to internalize what we're doing for them and it will build political support in terms of local government.

One director assisted this process by sending various reports to the local government.

I sent them annual reports, copies of site visits, and audit statements. When I go up there at the end of the year they can't say
"who are you and where did you come from?"
I also meet with them as a body. First, I just go up there and let them know what we've been doing and ask if they have any criticisms or feedback. It's very helpful because I don't want anything from them.

Another director, faced with a large number of towns with which to work, developed a novel, long-term strategy.

The first year I only went to Town A and made a specific request for funding which got approved. I couldn't go to all of the communities in a year. The next year I selected eight communities where there was established statistical information about our services. I then asked them to duplicate Town A. I then went to every community where we had a board member. I had a board member or a town representative for every meeting, who took responsibility. I would attend the larger meetings. We usually went to the budget meeting hearings or the finance committee.

Another strategy was to bring local government, legislative representatives, and the community to the center.

We had a meeting last year with local government, the state legislators from this region, representatives from the governor's office, and all the Congressional representatives. It was an informational meeting. We took them on a tour; showed them our MIS; the number of patients; the psychiatric unit; fed them lunch; and got feedback. It was good, well represented, educational, and informational. Clients were part of this. I also have ongoing meetings with local people (e.g., lawyers and businessmen)... When it comes time to ask for money they know about us and are supportive. One of the local guys wrote a press release after seeing the site visit report. They cut us because they don't have any money, not because they don't like us. We've done reasonably well getting local funds. I think it's because they know what's happening.
I let them know everything that's going on.

As with the state, center board members were used extensively as an interface and influence agent with local government and the communities.

I get our board people to go out and talk to towns. I'm seen as a city slicker looking for bucks; they are local people. The strategy is to, at first, not ask the towns for anything, but just let them know what we're doing; leave information; and find out if they have any problems with us. I'll go back in the fall for money.

In summary, although CMHCs only received 4-10% of their budget from local government, the center directors had to spend a large amount of time and relate to a number of local people in order to receive this money. Major topics of discussion with local government included information sharing, service delivery, and funding. The problems experienced by the directors in working with local government involved misperceptions concerning CMHC's wealth and power, excessive expectations about service and accountability, community discomfort with deinstitutionalization, and having to work with local people who were unsupportive of human services. The directors felt it was quite important to have positive community relations, so they developed a number of strategies to accomplish that goal: educating the community and local government through presentation of data, case examples, and publicity; going to town/city meetings with information about the center; bringing the community and local government to the center; and using board members as representatives.
Personal Alliances/Support

In asking the center directors about their sources of support, three groups of people emerged as primary sources of support. These were other CMHC directors and CMHC coalitions if they existed, center board members, and center management staff, usually top management. Other CMHC directors and coalitions were seen as especially helpful in information sharing and strategizing about broader systemic concerns. Board members were experienced as helpful in influencing people in the external environment, possessing large networks that the director could hook into, and also strategizing about larger systemic issues. Management staff were more supportive in relation to the internal environment of the organization. They were helpful with technical knowledge, knowledge of the external system as a result of previous jobs, strategizing about both internal and external planning, facilitating communication between bureaucratic levels, and interpreting the executive director's job to line staff. Particular members of the management staff were also helpful by just providing a friendly ear and a setting where the director could let his/her "hair down" and be open about the particular problems s/he was experiencing.

Other supportive people or groups mentioned included: other agencies, especially if they were in coalitions; management consultants; the NIMH Staff College group; the state Association of Mental Health; and one's NIMH project officer. The support gained from these
people and organizations consisted of information, personal and professional feedback, planning and strategizing, and developing power bases. Most of these relationships were developed through a combination of work and socializing. Interestingly, only one person mentioned home or family as a major source of support.

The following quote is a good example of how one center director went about developing a supportive network:

At a local level, there are key legislators who I would go directly to. They are state senators from this area who have a lot of interest in human services and special education. One is an active member of the state finance committee. I also go to the local hospital administrator. We have a contractual relationship and s/he's a peer. It can be quite isolated, although I also go to the individuals on the board. It comes down to people I develop an individual relationship with. I go to the state board of education when I need advice in that area. That developed out of an official basis. Some relationships I may formalize because I need the contacts. I get connected to key people, often through serving on committees. I end up knowing people informally through seeking or sharing information. When the legislature convenes and bills are being considered, I let the legislators know I'm available to answer any questions. Some of them take advantage of it. The NIMH has been helpful by letting me know about particular individuals who can help with a problem. They connect me to them. I think more of that could happen, but the coalition will try to do some of that.

A question that was asked of the center directors, and is related to the issue of alliance/support, concerned their internal versus external role in relation to the CMHC. That is, what percentage of time did they spend on tasks related to the internal functioning of the organization as compared to the external functioning. All the
directors felt that the top priority was to get their internal house in order, at which point they could and should turn to the external environment so as to address long term planning and global issues, and the external environment. Estimates of the percentage of time needed for external involvements ranged from 40-80%, with most seeing an ideal of 75%. However, to spend that much time externally, it was seen as essential to have a person within the organization fulfilling a role similar to that of deputy director. Otherwise, the internal needs of the organization would be neglected.

In summary, support and alliances for the CMHC directors came primarily from other CMHC directors, board members, and management staff. The support resulted from information sharing, strategizing, and friendship. Center directors felt that, ideally, they should be focusing on external organizational issues 75% of the time. However, they thought that would be impossible unless there was a deputy director to manage the internal organization.
In the space of one year sweeping changes have occurred within the CMHC movement. At the time of the interviews with the CMHC directors, Carter and Reagan were campaigning against each other; federal funding for CMHCs, although decreasing, was still a future reality for many CMHCs; and the Mental Health Systems Act was fighting its laborious way through Congress, accompanied by energetic lobbying attempts by various mental health coalitions and organizations. In short, although the situation was not as positive as when the CMHC legislation was first passed into law, it was not oppressively bleak either. Despite some philosophical changes and service emphasis, the Systems Act was basically supportive of the notion of comprehensive mental health services.

At this point in time, June 1981, the situation has changed dramatically. The Systems Act was passed by the Legislature and funds were appropriated for it, Reagan was elected president, and the financial situation for CMHCs is looking dire at best. Although the Systems Act was passed, there is currently a good possibility that Reagan will rescind that legislation and that block grant funding to the states will become effective as the funding mechanism for services that, in the past, have been funded directly by the federal government. If block grant funding is passed by the Senate and Congress, there will be
serious financial and philosophical repercussions for CMHCs. Regardless of the block grant decision, there will be major financial cutbacks (a 25% cut off the top at the minimum) due to Reagan's current budget.

In this chapter, major findings of this study will be reviewed and put in the context of these current legislative changes; limitations of this study and directions for future research will be discussed; comments will be made concerning the recruitment and training of CMHC directors and their support needs; and implications for community mental health ideology will be explored.

**Major Findings**

*Boundary spanning and role stress.* As was discussed in the literature review (e.g., Gabbert, 1960; Beigel and Levinson, 1972; Sharfstein and Wolfe, 1978; Whittington, 1975), CMHC directors found, that to insure CMHC survival, they increasingly had to focus on the external environment and its management. A variety of authors emphasize the need for CMHC directors to participate in interagency collaboration and coordination (e.g., Neugarten, 1975; Feldman, 1972; Agranoff, 1974); gain power (Levinson and Klerman, 1972; Racy, 1975; Zaleznik, 1967); and to become involved with politics, lobbying, coalition and network building (e.g., Armstrong, 1980; Dorken, 1981; Beigel, 1971).

Due to the uncertain and rapidly changing environment (Feldman, 1978; Mazade, 1978) and to the distinctive attributes of human service organizations (Feldman, 1972, 1975; Hazenfeld and English, 1974), the
CMHC directors' primary role is that of boundary spanner and environmental monitor. Planning and decision-making under conditions of uncertainty are routine, with many of the directors making planning decisions according to Baker's (1972) "outside-in" approach. Although the directors saw a perpetual need for long term planning, they felt frustrated because of continually changing budgets, limited long term planning by the NIMH and states, chaotic leadership and non-support of CMHC principles within the states, and disinterest in mental health on the part of the federal legislature.

The center directors, while focusing on external organizational issues (i.e., legislation, finances, marketing, and power acquisition through lobbying and network and coalition building), also agreed with previously mentioned authors (e.g., Felzer, 1970; O'Neill, 1970; Reese, 1972) that it was important to develop a strong organization internally, both fiscally and in relation to staff. Fiscal strengthening was reliant on techniques discussed by Gabbert (1980), including the aggressive pursuit of third party payments, client billing, and negotiations with the states for increased funding.

It seemed that the directors were comfortable with their clinician-executive role as described by Levinson and Klerman (1967), Hinkle and Burns (1978), and Kal (1971). The clinical training helped, both internally with staff and externally in explaining clinical services and problems. However, as with the administrators studied by Flynn (1979), the CMHC directors felt they needed additional administrative training.
In contrast to the hypothesis that CMHC directors would experience increased stress due to their boundary spanning role (Greenbaum, 1968; Kahn et. al., 1964; Miles, 1978, 1980), these directors, although frequently frustrated, seemed to truly enjoy their jobs and feel a deep commitment to the development of community mental health services. This may have been due to two factors, power and support. As discussed by the above authors, the boundary spanning role of CMHC director provides the person with an opportunity to experience a great deal of power, control, and influence and it was apparent these CMHC directors enjoyed those aspects of the role. Furthermore, these directors seemed to have developed relatively effective support networks (e.g., their project officers, other CMHC directors, colleagues, and management staff) who provided them with information and people with whom to strategize. For the most part, they seemed to enjoy the political process and the opportunity to outsmart the system.

NIMH relations. In contrast to the findings of Naierman et al. (1978), in general the center directors were unanimously positive about their working relationships with the regional office of the NIMH. The distribution of grant money directly to the centers was helpful in terms of financial planning, operations, and support of the CMHC ideology. Reporting requirements were seen as sane and manageable. The relationship with the project officer (specifically the technical assistance received), overall, was seen as quite positive; although there was some concern about the role conflict inherent in being both a technical assistant and a monitor. Finally, the opportunities for admin-
istrative training (especially through the Staff College) and consultation were appreciated and utilized. Vis a vis a government agency, the NIMH was seen as a positive entity with which to work and one that had built-in supports both for the CMHC director and CMHC ideology. Simplistic as it may seem, this is not particularly surprising since the CMHC ideology grew out of a NIMH/ADAMHA federal legislature collaboration and, therefore, reflects that policy. In light of this, it is not surprising that state and local government are less supportive of CMHCs, a chronic problem which has serious implications for CMHCs, especially in the current financial situation.

Those problems, which did arise with the NIMH, were similar to those discussed by Sharfstein and Wolfe (1978). Primarily, problems arose in negotiating the complexity of the fiscal process, in planning for long-term financial viability based on current rules and regulations, in dealing with the split that seemed to occur between fiscal affairs at the NIMH (i.e., the grant's manager) and program management, and in the concept of demonstration money. This last concern is particularly relevant in relation to changing legislation and the emphasis on state block grants. Although the original ideal of CMHC demonstration money, as discussed by Naierman et. al. (1978) and Morrison (1977), was to begin a process which would ultimately be supported by a variety of contributors, in fact, this has not been as successful as was hoped for. Part of this is probably due to changing financial times (i.e., limited resources nationwide), but some of the problem seems to lie with the NIMH's lack of foresight in working
with the states so as to develop them, philosophically and financially, into a support system for the CMHCs. Furthermore, when power struggles did occur, the NIMH was often reluctant to use the weapons available to it.

Although the directors interviewed felt they had extremely positive relationships with their project officers, there was the potential for serious problems with role conflict and unclear expectations due to the combination of technical assistance and monitoring functions. In the future, because of scarce resources, there is also the possibility of increased bias on the part of a project officer toward a particular center, thereby increasing the emphasis on the relationship between director and project officer. Other staff related problems concerned the difficulty in providing comprehensive and detailed technical assistance through one project officer, who was usually a generalist in training.

Finally, the directors had concerns about their career options and where they would go in the future. There is no established career path for CMHC directors and many of them seemed unsure where they would go from their current position, speculations included state commissioner level and federal policy-making jobs.

Relations with the Federal legislature. The major findings concerning the federal legislature were that the process of relating to the legislature is a time-consuming and frustrating job. As with writers reviewed in Chapter I (e.g., Johnson and Forrest, 1979; Mott, 1969; Freed, 1967), influencing the legislature so as to be included in and
protected by current legislation was seen as critical. However, there seemed to be a pervasive pessimism about the possibility of having much real influence. The directors felt powerless and as if they were of relatively low priority in relation to other national agendas. Basically, the question is: How important is mental health nationally, and within mental health, how important is community mental health? The strategies used to address this issue were consistent with those used by Dorken (1981), Byrne (1980), Robbins (1980), and included extensive network building between center directors, legislators, and their aides; education about and involvement in the center; and use of lobbying through the National Council of CMHCs and other lobbying groups.

On a positive note, center directors found relationships with their state representatives helpful in solving particular, federally related, problems that their center was having. Legislators were most helpful in unsticking grants which had bogged down or were proceeding slowly.

State relations. In almost every aspect the major concern in relating to the state was power acquisition. Whereas the NIMH was supportive of CMHCs and the federal legislature was somewhat oblivious to them, the state mental health authorities were actually seen as dangerous to CMHC principles. If not actively trying to eliminate CMHCs, they were, at best, simply not supportive. As elaborated on by Naierman et al. (1978), Foley (1975), and Okin (1978), the two major reasons for this
nonsupport were: 1. the consistently poor relationship between NIMH and the states and 2. the states' historical emphasis on and commitment to the chronically mentally ill. With an ever shrinking budget, the states are inclined to provide services for those who are most troublesome and visible, leaving those who are healthier without services.

Other sources of difficulties with the states were the following: 1. having to deal with large bureaucracies with unclear decision-making policies and poor leadership, 2. frequently changing staffs who were often inadequately trained and had little power themselves, and 3. funding mechanisms which were contract based and often involved deficit funding. In addition, discovering accurate, timely information was often an impossible task. All of these problems, while leading to general chaos within the state, also made it difficult to gain influence and power which would lead to a coherent policy regarding mental health. To complicate things further, and in agreement with Naierman et. al. (1978), dealing with the state was a far more politicized situation than working with the NIMH. Within the state there were many more competing interests, both within mental health and without. Thus, there was less support, less information, less power, and, often, more competition.

The resultant strategies were similar to those advocated by Gabbert (1980), Beigal (1971) and Dorken (1981). They were based on massive network building techniques (e.g., agency and CMHC coalitions, use of board members' influence, contact with state legislators, and
involvement with regional and statewide committees), coupled with data gathering and presentation as a source of pressure on the state. The goal of many of the center directors was to address statewide issues as much as possible (primarily through the CMHC coalitions and sitting on high level legislative committees) as a way of influencing overall mental health policy and gaining some control of the chaotic situation within the state. In addition to the above strategies, center directors emphasized the need for developing a sound organization through third party and client billing.

Local relations. Although the CMHCs interviewed only received a small amount of local money, the directors expended a great deal of energy in maintaining good relationships with local government and the community. This stance was primarily a result of the CMHC philosophy which requires CMHCs to be responsive and responsible to their catchment areas and reflects the philosophy of many of the authors writing about CMHCs (e.g., Beigal, 1978; Flynn, 1979; Neugarten, 1975). This view, however, did not preclude problems with local government and the community. Specifically, because CMHCs are so large, comprehensive, and visible, they are seen as relatively wealthy and not in need of local financial support. This also results in increased expectations of service provision because of their size, and anger if that service is not available immediately. Furthermore, they are seen as threatening by other community agencies who fear the CMHCs will acquire all of the power and financial support. As has been mentioned
previously, there is also the problem of dealing with a highly politicized environment. As we have moved away from the national and toward the local level, the environment has tended to become more political and less supportive, financially and philosophically. There is no such thing as technical assistance from the local government, but there are extensive demands for accountability.

In this arena the directors found that, in addition to network building, educating the community and local government about the CMHC and its philosophy, funding, and services was the most effective way of gaining the community's support. This was accomplished by publicizing services, going to city and town meetings, and using board members as representatives. Once the community knew specifics about the funding structure, philosophy, and services, they were more likely to be supportive financially.

Alliances, support, and moderators of stress. Although the CMHC directors did experience stress due to their boundary spanning role and to the size, complexity, and turbulence of the external environment, moderators of this stress did exist in the form of alliances and support. The primary alliances and sources of support for the CMHC directors came from other directors, coalitions, board members, and management staff. Support, here, seemed to be defined as whatever helped in performing the job of CMHC director. Specifically, that was information sharing, strategizing about broad systemic issues, helping to build networks, influencing people in the external environment, managing the internal environment, and providing friendship. In
agreement with McMichael (1978) and Cobb (1976), this support seemed to protect the directors from some of the potential stress of their jobs and also made them more effective through education and contacts.

For the directors, the pull between operating within the organization and focusing on internal management issues, and operating externally to the organization and focusing on environmental concerns was difficult to resolve. The problem was simpler if there was a deputy director, because s/he could focus his/her energy internally and the executive director could work as a boundary spanner. However, for those executive directors who did not have deputy directors, the dilemma was more of a problem and source of stress to due role overload.

Speculations About the Future

Based upon the current legislative and financial climate, the basic question really is: Will CMHCs exist in the future? If the Mental Health Systems Act is rescinded (which is possible), CMHCs, as they are known today, will probably not exist. They will certainly not exist in every state across the nation, providing 12 essential services to people regardless of their ability to pay. CMHCs may exist in states that are particularly supportive of the community mental health concept; they may exist in states where there are no competing services; they may exist because they have an especially good director who has managed to tap a variety of funding sources; or they may exist in decimated forms, lacking the 12 essential services and
surviving only because of serious retrenchment toward those most seriously needed, and abandoning those programs which are more preventive and health oriented. However, they will probably not exist as a nationwide, federally-funded program, with money going directly to the centers and technical assistance and monitoring being provided by the NIMH through the regional offices. In fact, it is quite likely the regional offices will not exist, since they are reliant on a federal CMHC program for their justification.

The elimination of, or cutbacks within, the NIMH regional offices would have serious consequences for the CMHCs and their directors. The NIMH, and its project officers, was the only government agency which the directors felt positive about. They felt supported philosophically, educationally, and financially. There were training opportunities and the distribution of funds allowed the directors a great deal of flexibility in developing programs. If the NIMH regional offices are eliminated or cut back, the center directors will be faced with limited technical assistance, fewer educational opportunities, possible changes in funding, and less support.

The changes within the NIMH regional structure would result primarily from the passage of state block grant funding. This would allow money to bypass the NIMH and go directly to the state where it would be divided up according to the state's wishes. Furthermore, it is possible that the money would not be earmarked as mental health money, but would come out of a pool designated for health and human
services. Thus, there is every possibility that mental health could be pitted against, for example, hospital outpatient departments. There is also some possibility that the money could filter down even further to the local government arena before decisions are made about its uses.

This scenario, which was predicted by Feldman (1978) and Mazade (1978), has implications concerning the comprehensiveness of CMHCs, the amount of political footwork that will need to be done, and the potential for competition between centers themselves and between centers and other agencies. At the very least, centers will lose the support of the NIMH and will have to contend with the politicking and possibly chaotic environment of the state and/or local government. At the worst, CMHCs may find themselves being punished as a result of the historically poor relationships between the states and the federal government.

Concerning the comprehensiveness of CMHCs, it is likely they will lose much of their current programming, resulting in a move back to an emphasis on services for the chronically mentally ill. The first programs to go will probably be consultation and education (C and E), outreach efforts, and research, followed by services for the elderly, alcohol and drug abusers, and children. Outpatient programs will become increasingly reliant on third party payments and client fees. Those programs which seem to be the most secure and have the best likelihood of being picked up by the state are those associated with the most difficult and ill clients (i.e., emergency services, aftercare,
and residential treatment). Basically, CMHC services would return to the requirements of the initial CMHC legislation, but exclude consultation and education. However, even these services are not guaranteed, since, based on current legislation, decisions about how to spend the money are left up to the states and there are no federal guidelines attached. The result is that comprehensive and/or innovative programming will be a result of individual center's efforts at developing funding sources for those endeavors. Strategies reflective of Gabbert (1980) focus on the development of separate, nonprofit corporations which could funnel money from profit-making projects to those which need subsidizing; the aggressive pursuit of third party payments and client fees; and contracting for services with nontraditional funding sources (e.g., employee assistance with profit-making businesses, and training institutes). Increasingly, the emphasis will be on utilizing sound business principles and the aggressive marketing of services.

In addition to coping with dramatic cutbacks, center directors are going to have to negotiate a more politicized environment. As was discussed in the results and the literature review (Naierman et al., 1978), moving from national to state to local levels increased the number of people to whom it was necessary to relate, increased the amount of politicizing required, increased the amount of chaos experienced, and decreased the amount of available power, support, and training. Thus, while resources are shrinking, including administrative resources, with resultant pressure on the director to focus
internally on the organization, there are demands from the environment for the director to build networks, sit on committees, lobby, and build coalitions so as to gain influence and power. These activities take a tremendous amount of time, require much education of staff and board in order to gain their support, and make demands on the directors to perform functions for which they have often not been trained (c.f., Flynn, 1979; Johnson and Forrest, 1979). However, it should be noted, for many of the directors interviewed this aspect of their job was often the most enjoyable. Of course, that attitude was expressed during a time when the NIMH was strong and available to provide substantial support. The situation is likely to become much more difficult once that support is removed.

Another problem that may occur as a result of the scarce resources is an increasingly competitive environment. Directors, who before, were willing to work on coalition building and sharing of information may be more ambivalent about that process. It is likely they will continue to value those activities if they are directed toward something which will benefit all CMHCs, such as the Mental Health Systems Act, Medicaid legislation, or National Health Insurance. However, competition is likely to arise around state contracts and funding, and federal grants. The result may be a decrease in information sharing and support, leading to more stress in the job. At a time when coalition building is of paramount importance, the possibility of inter-CMHC rivalry is at its height. Hopefully, CMHCs will be able to maintain their collaborative stance and serve as advocates
for comprehensive mental health services within, at this point, a state setting.

Directions for Future Research

Before discussing directions for future research, it is necessary to address some of the limitations of this present research. One of the most obvious is the small number of directors interviewed and the limited geographical spread, both in relation to NIMH regions and number of states. This makes it difficult to generalize and may also have influenced the findings, particularly in relation to the NIMH and the states.

Regarding the NIMH, the results may have been skewed in a positive direction, not because the directors were afraid to say negative things, but because they had particularly knowledgable, effective, supportive, and dedicated project officers. The findings of this research, as to the positive aspects of working with the NIMH, differ dramatically with the findings of Naierman et.al. (1978). Furthermore, an outside CMHC executive director, in reading the preliminary draft, commented that the support received from these project officers seemed somewhat atypical. As a result, suggestions for further research in this area would point toward broadening the number of directors interviewed so as to get a proportionately larger sample of project officers.

The limited number of states in which directors were interviewed had an effect on the ability to look at the problems, positive aspects, and strategies as they related to specific state organization structures.
Partially, this was due to not identifying particular state structures in order to maintain confidentiality, but, primarily it was a result of interviewing in only a few states. However, the possibilities for research in this area are tantalizing, especially in relation to state structures, an area examined by Naierman et. al. (1978). Comparisons of the problems, positive aspects, and strategies experienced by the directors could be made in relation to the following: state mental health authority structure; general state government structure; number of people and/or their training within each structure; poor versus rich and rural versus urban states; powerful versus weak and bureaucratic versus less organized state mental health authorities; and the number of competing mental health agencies within the state. Based on this dissertation research, there seemed to be implications for funding, management of the internal organization, coalition and network building, power acquisition, comprehensiveness of services, and survival, depending upon some of the above factors. It would, therefore, make sense to explore this area further.

As a result of questions raised in this dissertation, other areas for future research might include a more detailed examination of:
1. coalition building, both among CMHCs and other agencies and within particular types of states; 2. network building, particularly who the most important people are to know and how to go about developing those relationships; 3. support networks, including what is supportive and how they get developed; 4. the relationship between CMHC boards and directors; and 5. why the relationship between the NIMH and the
states never blossomed. Topics not covered in this research, but which are related would be useful to explore, include relationships with other mental health agencies, differences in leadership style, perhaps between men and women, and its impact on the organization; and training backgrounds and their respective strengths and weaknesses.

The Recruitment, Training and Support Needs of CMHC Directors

As in the literature review (Levinson and Klerman, 1967, 1972; Hinkle and Burns, 1978; Pattison, 1974), a perpetual source of discussion concerning the recruitment of CMHC directors is whether they should be versed in clinical or business skills. Rarely does the candidate for the job have both. It is clear from this research that both skills are required - clinical skills in order to understand the issues confronting the staff and to present realistic case examples to people in the external environment; and business skills to plan for financial viability and to manage the face of the organization. Traditionally, CMHC boards have been reluctant to hire business people as executive directors, instead hiring clinicians who have been promoted through the administrative ranks. This trend does not seem to be reversing, and is particularly strong in centers affiliated with medical schools, where psychiatrists are usually the ones chosen for executive directors.

The choice of clinicians as executive directors has certain implications, namely, that a great deal of training will be required to
make them clinician-executives. Some of this will occur as on-the-job training, but it was clear from the directors interviewed in this study that more is required, especially in the areas of finance, economics, marketing, and general business principles (Flynn, 1979; Forrest, Johnson and Ralston, 1978). Those who had had access to the Staff College at the NIMH had found it superb, both for its training and its network building. However, entry into the Staff College training program is limited and only a small number of directors per year receive training. The other significant source of training is that received through the NIMH regional offices.

As has been mentioned previously, there is some possibility the regional offices will be eliminated, resulting in a dearth of training. At a time when CMHC directors need to be especially adept at managing their organization through the use of innovative business strategies, they are faced with losing many of the resources that would have provided that training. One solution might be to pursue training independently (such as enrolling in an MBA program) with the CMHC board's approval and support, a tactic that was being used by one of the directors. Another strategy, which addresses the notion of support structures, is to use fellow CMHC and agency executive directors as sounding boards and aids in the problem-solving process. The potential drawback to this plan is the possibility of increased competitiveness due to fiscal restraints.

The support needs of a CMHC director cover a variety of areas. On a macro level (which is, of course, the hardest to control) needed
supportive structures included: 1. monitoring agencies which also provide technical assistance, 2. a distribution of funds through grant-like structures, 3. access to one person in a funding agency who can make relatively independent decisions, 4. funding authorities which are less bureaucratic and smaller in size, 5. legislators who are reasonably interested in and knowledgable about mental health, and 6. effective state and national lobbys, which can affect all of the above. Closer to the CMHC director, and consequently more easily influenced, required support structures include: 1. a supportive, well trained top level management staff, 2. a board which is both supportive and has extensive contacts, especially within the state and federal legislatures, 3. a large network of CMHC and agency directors who like to share information and strategize, and 4. a place to receive training, particularly as related to business techniques.

Summary Statement

In summary, the prospects for comprehensive community mental health programs and, thereby, CMHCs are bleak at this point. With the cutbacks in state and federal financial resources, there will have to be a corresponding reduction in services. Those services which do remain will probably focus on the chronically mentally ill or exist in centers where innovative business principles are being used. Certainly prevention programs, which are an integral part of community mental health ideology, will suffer. Although the notion of comprehensiveness may be in question, Reagan's economic policies
have succeeded in putting an emphasis on "community", a word which is central of the community mental health ideology. By instituting state block grants, Reagan is hoping to return some of the decision-making power to the community. Whether this will, in fact, happen is questionable, since the planning power is really being turned over to a political, bureaucratic, and sometimes chaotic state system. Unfortunately, the result may not only be a loss in comprehensiveness, but also in community. The absence of CMHCs will mean a loss of CMHC community boards, who are responsible for planning comprehensive mental health services for their community. At this point in time, the idea of comprehensive CMHCs seems to be a fading dream, with the waking reality being a return to limited services which focus on the chronically mentally ill.
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APPENDIX A
GOVERNMENT RELATIONS INTERVIEW GUIDE

I. Description of relationship with the federal (state, local) government.

1. Who are the people you primarily relate to in the federal (state, local) government?
2. What is their role in relation to you?
3. What topics do you discuss with them?
4. Who makes contact? How frequently?

II. Problems encountered with the federal (state, local) government.

1. What are the major problems you encounter with the federal (state, local) government?
2. Who are the specific people associated with these problems? What is their relationship to you? What is their involvement in the creation of these problems?
3. How have you handled the above problems/relationships? What are the results? What are you doing to avoid problems like these in the future?
4. How is the federal government helping you to become financially viable?
5. What changes would you like to see with the federal (state, local) government?

III. Positive aspects to federal (state, local) government.

1. What are the major positive aspects to relating with the federal (state, local) government?
2. Who is particularly helpful to or supportive of you within the government? What is their relationship to you? How are they helpful or supportive?
3. How were these relationships developed? Who makes contact? How frequently? Around what topics?
IV. Strategies used in working with the federal (state, local) government.

1. What is your long range strategy in working with the federal (state, local) government?

2. Do you have any alliances in dealing with the federal (state, local) government? Who are they with? What is their purpose? How were they developed? How are they maintained?

3. With whom do you strategize?

4. What do you see as upcoming issues with the federal (state, local) government? How are you going to handle them?

V. Relations with the internal organization about federal (state, local) government.

1. How do people within your organization see your role in relation to the federal (state, local) government?

2. How do you explain that role to the organization?

3. Who is most supportive within the organization of that role? How are they supportive?

4. Who creates the most difficulties within the organization concerning your external role? How do they make it difficult for you? What do you do in response?

5. Do the people internal to the organization feel that your boundary role interferes with the running of the center?

6. In looking at your total job, what percentage of time do you spend on external, government related issues and what percentage of time on internal organization management issues?