Reprinted from
HANDBOOK OF COMMUNITY PSYCHIATRY AND
COMMUNITY MENTAL HEALTH
Leopold Bellak, Editor

CHAPTER 20

Local Mental Health Program Administration

By WARREN T. VAUGHAN, JR., M.D.

Dr. Vaughan has had extensive experience in both community psychiatry and community mental health. In the field of community psychiatry, he has served as a psychiatrist on the staff of the Human Relations Center of Wellesley; as Clinical Director of the Children's Unit of the Metropolitan State Hospital in Waltham, Massachusetts, and Director of that institution's Day Hospital Project; and Associate Director of the Task Force on Patterns of Patient Care for the Joint Commission on Mental Illness and Health. At present, Dr. Vaughan is Special Consultant to the Children's Unit at the Napa State Hospital in Imola, California.

In the field of community mental health, Dr. Vaughan has served as Director of the Division of Mental Hygiene of the Massachusetts Department of Mental Health, and Director of Mental Health Programs for the Western Interstate Commission for Higher Education at Boulder, Colorado. He held the appointment of Assistant Professor of Mental Health at the Harvard School of Public Health for seven years, from 1952 to 1959.

Dr. Vaughan is a member of the American Academy of Child Psychiatry, and the Group for the Advancement of Psychiatry. He is a Fellow of the American Psychiatric Association (and a member of its Committee on Policies and Standards of Hospitals and Clinics), and the American Public Health Association.

Dr. Vaughan is particularly interested in child psychiatry and mental health practice. He is the author of some 25 monographs, articles, and reports on these subjects.

Local mental health programs and services embrace a wide range of activities which necessarily involve almost all elements of community life. Mental health is concerned with the everyday life of people throughout the community as they function in many roles in family, school, job and community life. Their living conditions, learning, work and recreational conditions; their ways of coping with sickness, and with aberrant and antisocial behavior all come within the purview of a community mental health program. The community mental health program is also concerned with research; it is interested in the extent to which psychopathology is manifested in the community, and the inadequate social and other conditions which foster such psychopathology. Finally, it is concerned with the professional and other helping resources in the community, with the recruitment and education of future mental health professionals, and with inservice training.

Obviously, the administration of so comprehensive a program will involve extremely complex relationships between individuals and organizations, for administration is concerned with those policies and procedures which de-

termine professional practices and establish relationships among mental health services and other organizations and groups in the community, and with the financial structure which enables the implementation of these policies and procedures. The manner in which a local mental health program is administered will, to a large extent, determine the success of the various clinical services and other mental health activities of a new program.

The development of local mental health programs has, in fact, become a national trend, which has been stimulated not only by the increase in federal, state, and local funds available for such purposes, but also by new developments in clinical psychiatry, and by new theory and knowledge derived in large part from the behavioral sciences. Local mental health programs enable the full implementation of such recent innovations as breaking down the barriers between hospital and community, moving the psychiatric care system further into the community, and broadening the concept of treatment.[21] New programs have demonstrated the practical value of help which is made readily accessible at time of need, and of continuity of care for individuals and families which is realistically based on the natural history of psychiatric disorders and family pathology.[7]

In terms of its organization, then, a community mental health program will encompass many varied professional activities including psychiatric treatment and rehabilitation programs, and also certain of the activities of many private and public agencies and individuals which are relevant to the promotion of mental health, the prevention of psychiatric disorders, and the early recognition and referral of individuals and families to various helping resources. Usually, these activities are performed in at least five distinct types of settings: a) out-patient clinics for adults and children; b) inpatient services in general hospitals; c) rehabilitation services (including day care) in clinics, general hospitals or special centers; d) information and education services to the public and to the professions and agencies concerned with mental health; e) mental health consultation services to individuals, agencies and institutions.

The first comprehensive community mental health legislation was passed by New York State in 1954,* with California following in 1957 with its Short-Doyle Act.[11,22] These acts provide the legal instruments which authorize and facilitate optimal action on the part of local governments in the establishment of local mental health services. They also provide state funds on a matching basis to help finance such programs. By 1959, Minnesota, New Jersey, Indiana and Vermont also had state aid programs for local services. By 1959, counties in Iowa, Kansas, and South Dakota had been authorized to levy taxes locally for community mental health services.[12a] By January 1962, there was a total of fourteen such state-local mental health programs.†

Typically, the first order of business in developing a new community mental

*The provisions of the New York State Act, and the organization and administration of the New York City Community Mental Health Board are described in Chapter 19.

†The fourteen states include: New York, in 1954; Indiana and Connecticut, in 1955; California, Minnesota, New Jersey and Vermont in 1957; Maine, South Dakota and Wisconsin in 1959; Oregon, South Carolina, Utah and Wyoming in 1961. (Source: N.I.M.H.).

health program is to provide needed clinical services. Preoccupation with clinical services *per se*, however, may contribute to a narrowing of perspective, a failure to consider the sociocultural milieu in which these clinical services are to be embedded. Ideally, the new clinical service will be viewed as just one element in a spectrum of services. Participation of key lay and professional individuals and groups in the over-all planning provides the means whereby these new services can be fashioned in accord with various social and cultural characteristics of the local community. The community mental health program is obviously the concern of more than a few mental health professionals, local administrators and elected officials who must approve budgets and allocate funds. It necessarily should involve all persons whose work and responsibilities are instrumental in affecting the life of individuals, families, groups, institutions and agencies. How to develop a local program which successfully involves all these individuals is indeed a challenge of local mental health program administration, and one which has intrigued many psychiatrists and other mental health professionals in recent years. Robert H. Felix has expressed the problem—and the challenge—as follows:

"Why is the community a crucial element in our national mental health problem? The community is the basic social unit for meeting the needs of people. Our needs for food, shelter, education, protection, health care, social life, etc. are met by a network of such units across the country. There are over 4,000 towns and cities of 2,500 people or more throughout the country. They include 168 metropolitan areas clustered about cities of 50,000 or more. These towns and cities are the front line in the attack on mental illness. The metropolitan areas obviously require a complex network of coordinated arrangements for meeting the needs of people, including their needs in our area of concern-mental health and mental illness. There are over twenty community mental health agencies in the Washington, D. C., area alone. Outside of the institutions which care for the seriously mentally ill, our resources for meeting the mental health problem are administered through community agencies. Also, such institutional groups as the family, the school, the church, and the like, which are assumed to enhance positive mental health and do a preventive job, are organized in community groupings.

If you were to draw a circle around the area which contains most of the factors related to the mental health or mental illness of an individual you would probably draw the circle around his community, recognizing, of course, that certain regional and national forces also affect him-but usually through their local counterparts. It would appear, then, that outside of institutions for the mentally ill and State and National mental health agencies, the community is the basic unit of organization in the mental health effort, and even these external agencies have to work closely with the community agencies in mental health work. The community is also perhaps the largest integrated geographical unit in which this kind of work can be done intensively." (pp. 38–9).[8]

When we take a close look at the current nationwide picture regarding community resources for mental health, we see very clearly the magnitude of the problem, and the need. Robinson, DeMarche and Wagle make two observations in their study for the Joint Commission on Mental Illness and Health that are especially distressing. One is the national neglect of millions of children with mental health problems, who in consequence are unable to

function effectively in the adult world that created their problems. The other is a widespread lack of understanding of how to launch and carry on mental health programs at every level from the national scene down to the smallest hamlet. Too often, efforts to formulate mental health programs are haphazard and uncoordinated, well-intentioned, but amateurish and without professional guidance. (p. 111).[1]

This nationwide study of community resources in mental health is particularly concerned with the development of basic helping services. It describes such services as were found in the 3103 counties in the Continental United States and reports on detailed studies of fifteen typical counties from the four Census Bureau regions-Western, North Central, Northeast, South. Four configurations of helping resources, ranging from sparse or lacking to rich, are noted. Such factors as type and size of population, area, population density, mean income, manner of livelihood, age of community, and sociocultural status of the population were found to differ for each configuration. Robinson and his colleagues conclude: (p. 377)[20]

". . . many communities were very poorly supplied with most of these services. Even the larger cities were short on resources. The smaller agricultural communities were without most of them and the services that were present were not equipped to do much in behalf of mental health because of limited funds and undertrained staff."

They state, however, that in all but a few counties there exists a base of resources on which to build, and recommend several lines of action which have relevance to local mental health administration:

a) to study the significance of the variety of community settings;
b) to determine the need for consultation to local communities;
c) develop manpower for the supportive services;
d) community research and experimentation. (idem, p. 379)

Lack of facilities as well as the nationwide lack of trained professional manpower points to the absolute necessity for local mental health administration to be concerned with training and recruitment programs. And, in fact, communities which have highly developed mental health programs also have well-developed training and research centers nearby. However, all communities with research and training centers do not necessarily have strong local community mental health programs. No local mental health program can move forward faster than the citizens of the community it serves and their social and political leaders.

Informing and orienting community leaders regarding the positive value of well-supported mental health services to the community is a continuous job, never completed. The only persons who can do this vital job of community education and orientation are our trained mental health professionals themselves. *Action for Mental Health* discusses this as follows:

"Local communities can hardly be blamed for their failure to initiate effective programs in behalf of mental health. Undoubtedly the desire to take action is universal. But the presence of will does not guarantee a way. Hence the second point of central importance that emerges from *Community Re-*

sources in Mental Health is this: The initiative for the creation and development and coordination of mental health resources in communities rests solidly with mental health leaders. It is up to them to show the way. And in the process of helping to develop these resources, they will have to recognize and learn to live with their reliance on many other individuals who, by the force of circumstances, are involved in the treatment of mental and emotional disturbances." (p. 123).[1]

Mental health professionals are ordinarily trained in a clinical context and are particularly interested in applying their knowledge and skills in direct work with sick individuals and families with problems. Administration as such has not only been neglected as an important and essential facet of the professional role, but also has too often been denigrated, with administration viewed as an activity involving shuffling paper, the collection of meaningless statistics, and impeding rather than helping the work of clinicians—a line of work practiced by those who cannot "make the grade" in the higher status clinical field. This attitude towards administration has seemed to be particularly strong in relation to public programs (in contrast to administration of private and university programs). By the same token, the practice of paying low salaries to mental health professionals in public service seems to be related to the low value which is often placed on mental health services by the community and its leaders. Such negative attitudes and stereotypes which may be held by the public as well as the professional world further complicate the problem of local mental health administration. The mental health administrator for instance, must necessarily be concerned not only with the status, the working conditions, and the value placed on the mental health job, but also with other professional activities in the public sector. In some communities, the local mental health authority has not been able to hire a local program director until the salaries of other professionals in public service have been raised to a more appropriate level, commensurate with that being sought for the mental health program director.

In view of the necessarily broad concerns of mental health with so many aspects of community structure and community life, as mentioned above, a principal task of administration is to work with a wide variety of individuals and agencies in the community whose activities are relevant to mental health. Mental health administration involves *communication* and *program coordination* with many disparate elements in the community, which nevertheless have common mental health interests. The involvement of many community groups and individuals in a mental health program implies that the various groups can develop similar mental health goals, though the motivations for involvement may remain quite disimilar. Regardless of motivations and vested interests of both a personal and institutional nature, many individuals and groups must come together in cooperative and collaborative activities in order for the mental health program to move forward.

In 1958, Dr. Charles A. Roberts, former Principal Medical Officer for Mental Health of Canada's Department of Health and Welfare, and Dr. Curtis Southard, Chief of the Community Services Branch, National Institute of Mental Health, visited eight community mental health services in the United States and Canada for the 1958 Milbank Memorial Fund Conference

on Progress and Problems of Community Mental Health Services. Their two papers in the proceedings of that conference are perhaps the most highly developed statements to date on community mental health administration. The following quotations from these papers are particularly relevant to this discussion:

"The primary purpose of administration is to get things done—thus an administrator can only function when the objectives of a program have been clearly stated. The aim of a successful administrator should be to develop others and thus to increasingly delegate more and more authority—the administrator should not control or dominate but should work to develop cooperation and integration of many services which come under his over-all supervision. Administrators should give more and more attention to motivation and incentives and should increasingly understand the laws of institutional living. The administrator has four primary responsibilities:

To plan,
To organize,
To direct,
To represent,

and in order to carry them out must be concerned with personnel management, financial administration, and legal administration, i.e., operation of the program in terms of the prevailing laws and policies of the authority under which the program operates—board, state, municipal, or federal department. The other important item in this respect is the budget—an administrative and financial device which should be a financial plan of operation." (pp. 63–4).[19]

"It is not unusual to find individual psychiatrists, psychologists, social workers, nurses, and others express surprise and amazement at the help they have received from administrators, whether lay or professional, when the latter were given an opportunity to review programs in detail, to help with budget preparation, and to suggest operational procedures. It appears that workers in the mental health field where we are so concerned with the team approach, with cooperation within a wide range of other services, and increasingly with very large budgets should certainly have some training in administration, and selected individuals should now make this a speciality within their chosen professional field." (pp. 62–3)[19]

"I have seen health departments where community mental health staff are isolated from other parts of the health department and where the mental health program receives only grudging support. Similarly, in hospital agencies, I have seen mental health staff overwhelmed by the task of treating the mentally ill in a setting where there is little understanding and support of promotion and prevention. I have also seen independent mental health agencies isolated from both the public health department and the hospital.

Organizational setting is important, but I suspect that in the final analysis, the caliber and convictions of the professional staff, and especially the quality of leadership, largely determine the success of a program.

No matter what organization settings are used to provide mental health services, every community should have a planning and coordinating body for all aspects of its mental health activities. The program should be planned and directed by professional staff with the assistance of qualified administrative staff. Staff should have time for planning and working in the community, free from pressures of service operations." (pp. 92–3).[19]

"PARTNERSHIP" IN COMMUNITY MENTAL HEALTH WORK

The nature of the cooperation and collaboration in community mental health is probably best described as a "partnership." Partnership implies that all of the individuals and groups involved maintain their own freedom of action

and decision, indeed are urged to recognize and exercise this freedom, but meet together with other persons and agencies in order to delineate the specific actions each will carry out individually as his contribution to the general mental health goal. The dynamics of the partnership contrast with the dynamics of a typical hierarchial line organization, such as a school, health or welfare department, where decision-making is done at the top, with orders sent down the chain of command. The local mental health administrator has such familiar types of line relationships only within his own service organization, where he has direct responsibility for the organization of service programs and for the work of professional personnel. The partnership organization involves individuals and agencies which are both representative of various elements of the community and responsible for certain community activities which have relevance to mental health. These persons have peer relationships to each other, rather than subordinate-superordinate relationships. Each has major responsibilities in his sector of community life which are either explicitly assigned by virtue of professional or organizational role or implicitely assumed by virtue of interest in mental health. The development of the partnership is marked by the following sequences:

a) definition of and agreement upon a common set of goals;
b) the development of emotional involvement and a sense of ownership and pride in the mental health enterprise by the partners;
c) growth of the partnership to include additional individuals and agencies wanting to join;
d) the definition for each partner of his specific roles and functions in the program;
e) commitments assumed by the partners for jobs to be done by each to move the program forward;
f) strong executive direction from the local mental health authority and its representative, with constant attention to maintaining lines of communication within the partnership and the active involvement of the partners;
g) periodic review and evaluation, amendment, restatement and clarification of goals and commitments.

For purpose of analysis and discussion we choose to consider membership in the partnership to be comprised of a number of axes, made up of dyad and group relationships as follows: a) *state-local;* b) *public-private;* c) *professional-lay;* d) *interagency;* e) *interdisciplinary.* Each of these axes are discussed in turn below, and their important contributions highlighted.

A. The State-Local Axis

There can be no local mental health program without state involvement. The authority for conducting local mental health programs as well as the all-important financing of them derives from the state, as provided by its constitution and through legislative action. As the state moves to fulfill its responsibilities and commitments within the partnership, it can develop a number of functions which are outlined and discussed below.

1) financing of local services

There are several ways in which state funds may reach local mental health programs. First, state funds may be allocated in the form of direct grants-in-

aid, with state reimbursement for local services on a matching basis. This method, long used in education, welfare, public works, correction and other programs, has been incorporated into the new state-local mental health legislation.* An older method, still in use in many states, is the assignment of professional personnel who are state employees to work in specific community programs. Again, the state may feed funds into a community program by contracting with local private agencies to conduct service programs, and by purchasing of specific services as rendered by local public and private agencies. These funds may come from other than state mental health sources, such as welfare, education, and state rehabilitation services, and are often obtained by the states in turn from the federal government. Since 1947, federal funds have been apportioned to the designated mental health authority in each state to stimulate the development of community mental health programs. In 1962, eighteen states used the state health department as the mental health authority, although the responsibility for mental hospitals and institutions for the retarded was assigned to other departments. In thirty-two states the mental health authority was also responsible for the mental hospital program. Twelve of these states had a single department of mental health or hygiene. In three states, a state health department, and in three others, a state department of health and welfare assumed the responsibility for both hospital and community services. Agencies of the remaining fourteen states with a single mental hospital and mental health authority, the agencies in two included a department of institutions, one, a department of hospitals, five, a department of public or social welfare, two, a department of mental health and correction, two, a hospital board, one, a state commission, and one, a state board of control.*

The establishment of the hospital authority and mental health authority within a single state agency has been strongly recommended for a number of years by leaders in psychiatry and mental health. Considerable progress in this direction has been made in the past few years.

Federal funds for research, training and special projects designed to explore new ways to develop mental health services may be allocated directly to local mental health programs, especially those with university affiliations.

2) *state concern with the type and quality of local services*

The state is responsible for the quality of services rendered by local programs to those individuals and groups which are eligible for such services. Some states have a licensing program for local clinics. Others require that certain conditions, such as stated qualifications of personnel, be met before reimbursement is allowed. Of course, the states which assign professional personnel directly to local programs attempt to assure professional competence through the hiring procedure itself, which is often conducted within the civil service system of the state.

The state agency has a continued responsibility to raise professional standards and improve programs. It does this through its budget justifications for increased salaries, expansion of existing programs, and other activities de-

*See Chapter 19.

scribed below. State mental health associations, medical societies, parent-teacher associations, parents of mentally retarded children and others have worked at informing and orienting legislators regarding mental health needs. The professional associations in the state may also be directly concerned with professional standards and the quality of services.

3) *the services of community organization specialists*

State mental health authorities have discovered that they themselves must take considerable initiative in bringing mental health programs to local communities. They have had to develop community organization specialists who respond to interests and inquiries from local community groups, as well as initiate contacts with key individuals and agencies in local communities.

The community organization specialist brings information to communities regarding the development of local programs, and plays an extremely important catalyst role in helping to begin the formation of a community partnership in which all the various individuals and agencies concerned with mental health are represented. Arthur Hallock in Massachusetts, Hyman Forstenzer and the late Luther Woodward in New York State were the pioneers in this work. The community organization specialist also serves as a liaison person between neighboring local services. He organizes statewide conferences and associations for the leaders of local mental health programs. There is a growing body of literature on the work of state-level community organization specialists.[2,5-7,11-13,17,23]

4) *mental health education and orientation*

Community organization specialists work very closely with local voluntary mental health associations. They also work closely with mental health educators and others in the development and use of films, pamphlets, brochures and other materials to aid in the orientation and education of local professional and lay groups. Some state mental health authorities have mental health education services which provide mass media material for local newspapers, film libraries and rental services, the preparation and loan of exhibits, technical assistance in developing local mental health education programs.

5) *long-range planning and development*

The state mental health agency does long range planning. It involves representatives of the mental health professions, lay persons and others on study groups and special committees. These studies are extremely important to state legislative councils and budget officers in their long-range fiscal planning. The reports of such state study and planning groups can be of great value to public officials and professional groups in their information and education work.

6) *in-service training*

Many state mental health agencies package and deliver in-service training programs to professionals in community clinics and centers as well as to those working in state institutions. Sometimes the states simply approve and finance such programs. More often, however, professional personnel in the state agency work directly to develop in-service training programs, short courses, conferences, workshops and institutes. The National Institute of Mental Health through its technical assistance program often aids in the financing

and development of such programs. In recent years the interstate higher education compact agencies of 15 Southern states and 13 Western states have entered this field on a regional basis.*

7) *professional training*

The state mental health agency is concerned, sometimes directly, but most often indirectly, with the development of university training programs, internships, and residency programs for mental health professionals. The state mental health agency plays a catalyst role, trying to stimulate the development of more such programs in the mental health professions. Often, the state stimulates the development of residency training programs administered jointly by state institutions and local community mental health agencies. Sometimes students and trainees are able to arrange traineeships and junior staff appointments financed by state funds which include placement in a local mental health program.

8) *recruitment programs*

State mental health agencies are becoming increasingly involved in recruiting young people into the mental health professions. In the Western states, this has most recently taken the form of summer work-study programs for college undergraduates and graduate students. This program, under the sponsorship of the Western Interstate Commission for Higher Education and its Council on Mental Health Training and Research, began in 1960. It can now boast of some former summer interns who have been placed in community mental health programs as well as state and other institutions. College student volunteer programs, closely tied to courses in sociology and psychology, have been developed jointly by some universities and local mental health programs.[12b]

9) *research and evaluation*

States require annual reports from local community mental health programs which receive state funds, or to which state professional personnel are assigned. These reports require that local programs be carefully reviewed by staff every year. Many states now realize that effective long range planning in the mental health field requires that research be undertaken within the state itself. The complexities of any mental health program are such that clinical research and program research conducted elsewhere may not necessarily provide the answer for a particular state. Basic clinical and laboratory research is now being financed and sponsored by some state mental health agencies but these research funds are still but a "drop in the bucket" compared to total funds expended by these states in their mental health programs. Mental health administrators, state officials and legislators are slowly beginning to recognize the relevance of research, training and professional education to the quality of service rendered to patients.

10) *consultation services to other state agencies*

Mental health agencies provide consultation services to other state agencies which are concerned with human services in local communities. State de-

*Western Interstate Commission for Higher Education, Boulder, Colorado. Southern Regional Education Board, Atlanta, Georgia.

partments of education and mental health collaborate in designing special education programs for the mentally retarded, and emotionally and physically handicapped children. Mental Health, public health, welfare and vocational rehabilitation agencies work together in programs for the handicapped and disabled, and the alcoholics. Mental health agencies, correctional agencies and youth authorities may work together on special programs. These and other inter-departmental activities at the state level are of great importance to local mental health programs.

11) *direct medical services*

All of the foregoing state-level mental health activities expend a very small portion of the total state funds appropriated. The vast majority of state funds go into direct services in state institutions for the mentally ill and mentally retarded. However, these institutions are themselves becoming "community resources" in many parts of the country.[7] Administrators of mental hospitals are frequently in the vanguard of professionals interested in local mental health program development.[10] The state institutions are no longer so isolated, thanks to modern transportation and the growth of communities to surround them.

The number of state responsibilities in the state-local axis is impressive. State responsibilities have increased rather than decreased as the trend has moved towards local mental health programs. However, a natural tendency has existed for state personnel and agencies to try not to "interfere" in local programs, sometimes to the point of "bending over backwards" not to infringe. This has its hazards, as brought out in *Action for Mental Health*:

"The desire to develop mental health resources is everywhere. But too many communities are left on their own to work out problems as best they can. Initiative must be taken, logically by the states, to provide consultation for local community planning."

Stanley P. Davies[5] has written as follows in discussing the New York program in the monograph, *Towards Community Mental Health:*

. . . the question inevitably is raised: Did the state mental health officials follow more of a hands-off, laissez-faire policy than was necessary or desirable without violating the principle of home rule? The localities were making a brave beginning in an uncharted field with new and inexperienced boards and directors. Should they have been left so completely to find their way on their own? The state personnel had more knowledge and experience in the general field of mental health and the benefit of the studies, experience and findings of the Mental Health Commission. Without semblance of interference or dictation, should they not have been more ready upon request to participate in local discussions of plans and policies, to advise in making a sound survey and in determining criteria and priorities? Looking back it would appear that in a number of localities, especially those where existing services largely took over the mental health program before there was opportunity to study, to plan and to select, a voice of wisdom and experience from the state level would have been very helpful. The state cannot and should not stand aloof from the development and operation of a program for which it foots half the bill.

. . . The conclusion is that the state should not lean over backwards in deference to home rule. There are much needed kinds of leadership that can come only from the state and that, if rightly used, will strengthen, rather than weaken, local initiative and performance." (pp. 26–28).

These conclusions regarding the New York State program seem applicable to all states. Each state should have experienced, flexible and imaginiative professional personnel who understand the potentials of the state's role as catalyst, "middle man" or "honest broker" between local mental health services and such institutions as universities, local welfare, education, health departments. State support of in-service training, professional education and recruitment, as well as research programs, is of inestimable value.*

The "local" member of the state-local axis is, in the widest sense, the entire community. The community is represented by the person, board, committee or association which has assumed the responsibility for local mental health program administration for a particular population group with certain geographic and political boundaries, which we call the "community." Ordinarily, the state mental health representative consults or "clears with" this local authority whenever he makes a personal visit to the community. In those states where the community mental health program is operated from the state level, the community partner is usually represented by a private incorporated mental health association or clinic agency (e.g., Massachusetts.).[2,12,13] In some of the states which have enacted new community mental health legislation, such as New York State, the local partner is a mental health board.[11] Certain board membership characteristics are determined by the legislation in order to insure participation of public health, medical care, education, welfare and the courts in the local mental health program. In other states, such as California, the local mental health authority and responsibility is usually vested in the county or city health department, although the county hospital director or a separate mental health department director may be designated as the local mental health authority.[21]

Regardless of the location of the local mental health authority, the practice in all programs is for a mental health professional, specifically, a psychiatrist, to be hired and appointed as mental health program director, or program chief. It is of interest that the new community mental health legislation places the authority to hire, fix salaries, and to designate specific duties and working conditions in the hands of the local community. One of the most crucial phases in the development of the partnership at the local level is the recruitment and hiring of a local program director. Ideally this should actively involve all members of the partnership. Psychiatrists who are oriented and experienced in community mental health program administration are in extremely short supply, and many communities, in their eagerness to find a

*The most complete account of a community oriented, state-operated service is provided in E. Cunningham Dax's *Asylum to Community: The Development of the Mental Hygiene Service in Victoria, Australia*, published for the World Federation for Mental Health in 1961. Examples of the "partnership approach," and its success, abound throughout this most comprehensive account to date of the development of a modern program.[6]

psychiatrist, have not spent enough time and thought on the hiring process; nor have they involved enough people in the community in this procedure. When all members of the local partnership have participated in screening the candidates, orienting them to the community, its needs and interests in mental health, and have reviewed with the candidate those factors of community life which are of personal interest to the candidate and his family, they are perforce very involved and interested in the program before it is even under way.

Intimately related to the selection of a program director, are a) the formulation of long range program goals, and b) the committment of funds to conduct the program. The state community organization specialist and resource persons both within the community, and from outside, can help a community to formulate its long range goals. The local community should also be prepared to review their candidates.

As the local partners begin to develop their organization, they will necessarily attempt to inform themselves regarding the community's mental health needs and resources. The *self-survey* has been used by many communities for this purpose.[9] Discussion of the findings and implications of a self-survey, along with the development of priorities for specific programs, provides an opportunity to involve even more individuals from various sectors of the community in the mental health program partnership. At this stage, and even earlier, many communities begin to realize that local public officials, both elected and appointed, must be oriented and informed regarding mental health goals, local needs and proposed activities. This initial failure to involve legislators and other public officials in a local mental health program will result in unnecessary misunderstandings and blocks to program development later on.

In summary, the local partner must make crucial decisions and take action regarding the following aspects of the local program:

a) identifying the community's needs through careful studies and self-surveys; establishing long term goals, setting of priorities for local program development;

b) recruiting and hiring of a program director;

c) arranging for professional services, by contract and/or by hiring personnel; establishing appropriate salaries and other conditions of employment;

d) arranging for necessary nonprofessional personnel, and for housing, housekeeping, equipment and supplies, telephone, postage, printing, travel and so forth.

e) establishing a system for periodic review and evaluation of the program.

The proper execution of these responsibilities is usually done by delegation of various jobs to appropriate committees or study and review groups which are made up of the various public, private, professional and lay individuals and groups in the partnership.

B. The Public-Private Axis

The nature of the public-private axis in the community mental health partnership is dependent to a great extent on the local organization of help-

ing services and the nature of the state-local relationships. In all community mental health programs either a local or a state public authority assumes the major responsibility for programming professional activities. As in public health, mental health program development is conducted in the public domain and under public authority. A major involvement of private interests in planning and carrying out local mental health programs has been described in Massachusetts by Hallock and Vaughan.[12] The community mental health boards in New York have private citizens as members, and in California there are local mental health advisory groups on which private professional and lay interests are represented.

1) *private professional participation*

Organized private interests and efforts in mental health are ordinarily taken by local mental health associations and by community health and welfare councils and their members (such as family agencies), by private psychiatrists, other physicians and mental health professionals. Public mental health representatives work closely with these organizations and individuals, and participate in their committee and study group activities. The public mental health authority does not relinquish any of its responsibilities to the private group, but may look to them for direction regarding long-term goals, and priorities in particular. The private groups conduct their own appraisal of the program, ask themselves if they are satisfied with the program and if they approve of the manner in which the program is developing its clinical services and its consultation and educational services.* Private professional organizations, in particular the local medical society and its psychiatric section may play a major role in these activities.†

2) *participation of private lay-groups*

The community mental health program can move forward only with broad citizen involvement and support with an accompanying identification with and sense of "ownership" of the program.

The private lay groups may contribute directly to the mental health program through a) general financial support, or support of special aspects of the program, b) sponsorship of various specific activities, c) active participation in public relations, information and education, including lobbying, and finally, d) by personal participation in volunteer service programs.

---

*Typical examples of such activities by private organizations with which the author is familiar, would include, on a *national* level, the Canadian Mental Health Association's studies and reports on mental health services; on a *state* level, the Connecticut Association for Mental Health's study of psychiatric in-patient services in general hospitals; on a *local* level, community council studies undertaken in Los Angeles County and San Francisco on mental health needs and resources, and in Baltimore, on psychiatric in-patient services for children.

†At the national level, professional associations have long taken the leadership in establishing standards and guidelines for program development and professional practices. Important to the local mental health administrator is the work in this field done by individual professional organizations: the Joint Commission on Accreditation of Hospitals and the American Public Health Association. The American Psychiatric Association and the American Association for Mental Deficiency are specifically concerned with standards for psychiatric hospitals, clinics, schools, hospitals and other facilities for the mentally retarded.

Lack of healthy, well-developed public-private axis in the partnership results in a mental health program which is quite limited in scope, and which may focus primarily, for example, on providing limited clinical services for the medically indigent. Such programs usually have poor financial support and very meager training and research activities. The interchange between public and private interests represents the means by which the mental health program builds good will and gains the confidence of the community. The development of a public-private axis results in having people involved in the program who, by their very involvement, bring with them the community's "seal of approval." This axis represents the "heart" of the mental health organization and program. Its healthy development assures the balanced representation and involvement in the program, which is so important at times of program review, budget preparation, presentation and review. Of course the mental health program director must be aware of the vested interests of various groups and individuals in relation to the mental health enterprise. He must work with many different types of individuals; and in some instances the motivations underlying their involvement in the mental health program may outrule their possible contribution.

C. The Professional-Lay Axis

Professional-Lay Axis. The professional-lay axis of the community mental health partnership overlaps to some degree with the public-private axis. Members of the partnership may "wear several hats," such as public-lay (local legislator, public official) or, public-professional (public health officer, school superintendent), or professional-private (clergy, physician, lawyer).

1) *roles of professionals*

In general the professional members of the partnership should be active in guiding program development and in the evaluation of its services. The public and private professional groups concerned include public health, medical care and organized medicine, education, welfare, the clergy, and the legal and law enforcement professions. It is up to the mental health program director and other leaders to make maximum use of the time and interests of these professionals.

2) *roles of lay organizations and individuals*

The lay membership in the partnership has important functions as outlined above, under "private lay groups." Participation grows out of personal interest of individuals to be sure, but the membership should also reflect the interest of the general public. The lay participation should be developed in such a way that various important power groups are represented: special interest groups, civic associations, service clubs, business and labor organizations, parent-teachers associations, taxpayer associations, and various socioeconomic and cultural groups in the community. The importance of these types of representation is well recognized by community organization specialists in fields other than mental health.

The organization of community activities in which lay groups participate, which are related to mental health educational services, is a never-ending process and is a vital part of community mental health practice.. In con-

trast to the clinician whose interest focuses on the patient, the community mental health practitioner focuses his attention on the various subgroups of the community itself, and strives to build strong community participation in the program.[9]

D. Interdisciplinary and Interagency Relations

The word "team" has been used for many years to describe the interrelations between the professional mental health disciplines in direct services to individuals and families, and the collaboration of various helping agencies in specific program development. The interdisciplinary clinical team usually includes a psychiatrist, a social worker, a clinical psychologist and sometimes a psychiatric or mental health nurse. As community mental health programs have been developed, these three team members often have special functions in mental health consultation and mental health education. The three man clinical team is expanded in special programs to include other professionals, such as pediatricians, psychiatric nurses, mental health nurse consultants, special educators, occupational, recreation and music therapists, vocational guidance specialists and others.

Interdisciplinary cooperation in both program development and case collaboration is also considered essential in professional education programs, in-service training programs, and in research. Interagency cooperation and collaboration is found not only in direct case-centered helping activities and in consultation and education programs, but also in the top-level committee work of community councils and other program planning and evaluation groups.

Interagency case conferences for planning help to juvenile offenders, multiproblem families, persons returning from mental hospitals, handicapped persons and others have been developed in a number of communities in recent years. These organized programs are model examples of "partnership" activities between the mental health disciplines and between agencies. The administrator is concerned that the roles and functions of the professionals and the agencies involved be explicitly defined, and that the training and experience of those professionals involved be adequate for the responsibilities assumed. He is also concerned that scarce professional personnel and time be used in the most productive manner possible to move the overall program towards its stated goal.

THE LOCAL MENTAL HEALTH PROGRAM ADMINISTRATOR

The local mental health administrator is a new type of public official. He is a highly trained professional, a person who, by virtue of his office and the manner in which he discharges his professional duties, is potentially a powerful agent for effecting changes in many facets of community life. In order to fulfill his responsibilties, he should first be highly trained in the practice of psychiatry and have the ability to direct clinical programs and to supervise treatment of patients with psychiatric disorders. In addition he needs considerable knowledge of the biological sciences, the behaviorial sciences and working knowledge and skills in the fields of administration and

community organization, and in the use of group techniques in therapy and education. With his highly trained staff, he usually has the mandate, indeed the obligation, to be concerned with all social and other practices and procedures of various community agencies and institutions which have relevance to the mental health of the individual.

As community mental health programs are being developed across the nation, this potential for promoting change which is inherent in this new public office is often obscured, or insufficiently emphasized by mental health professionals because of their usual preoccupation with direct services to psychiatric patients. Furthermore, the power to initiate change inherent in the position of administrator of the local mental health program is often not recognized by responsible community leaders, both because of the lack of information and orientation and the overwhelming need to focus first, on developing adequate clinical services.

Psychiatrists themselves who may be interested in such work have had little opportunity to receive specific training in community mental health administration. Training in such rudimentary administrative matters as personnel administration, budget preparation and control, the medical audit, and how to work effectively with public officials, private groups, and so forth is lacking. The 1959 Conference on Mental Health Teaching in Schools of Public Health stressed the need for special training and orientation of psychiatrists who are moving into this field.[16]

Some individuals have speculated as to whether a program director must, in fact, be a psychiatrist, for this implies that he will then have to learn new skills in administration and public health. Could not, for instance, a highly skilled public health administrator conduct such local programs? Davies[5] discusses the prevailing view of this matter as follows:

"It is part of the unending debate in many fields. One side is that the director should be chosen for the administrative capacity which it is said is not often found in a professional person, who anyway should be giving all his time to professional practice. In this particular connection three things may be said. First, as a practical matter in the rural county the psychiatrist is called upon to double as clinician and director. Second, the director can look to members of his board for much useful and specialized counsel. Third, in public health experience, with a few rare exceptions, the administrators and leaders have been physicians trained in public health methods. The public health record is a proud one. So it would seem that the young and growing field of community mental health would do well to raise up its own leaders and specialists who would add training and experience in public mental health to their qualifications in medicine and psychiaty. . . . It is recommended that no change be made in the requirement that the director be a psychiatrist." (pp. 20–6).

We believe that the local mental health director has primary responsibility for the development of the partnership, and that in order to fulfill this responsibility, he must be a highly trained and experienced clinician. He is constantly using his clinical knowledge and experience as he works with public officials, private professional groups, sister agencies and mental health person-

nel. His influences, conclusions and decisions—which largely determine many policies and procedures—must be based on a sound understanding of clinical psychiatry.

The program director is principally concerned with caretaker agencies and individuals and works to develop and maintain open lines of communication between these persons. His long-range strategy is based on his study and understanding of local customs and patterns of services. His understanding of the community will also determine the tactics he applies to attain short term goals.

The administrator and his staff must view the community organization task as a continuous operation, recognizing that resistances in many sectors of the community are to be expected. It will take considerable time for the mental health staff to learn about all the available community services and to get to know key personnel in the community. It will also take much time and patience to learn about the informal as well as the formal structure of the community, the manner in which major decisions are made in the community. Mental health education and consultation becomes woven into local mental health administration and community organization. For instance, when a new clinical service is established, the first contact with allied helping agencies is usually through the process of direct referral of very difficult cases. If the focus of the new program is principally on patients and clinical services rather than on those persons in the community who provide other helping services, the director is apt to overlook important organizational aspects of the referral. Each such referral carries with it certain implicit notions, for instance, that the referring agency is not competent to handle the problem, and that by accepting this case, the mental health agency has indicated its willingness to relieve the referring agency of other similar problems it may have. The mental health administrator must realize that simple referral and acceptance of difficult cases is in itself no solution to the chronic mental health problems of various agencies and groups in the community. Acceptance of the referral may be necessary but is not enough.

Referring individuals will present their problems to the new mental health agency as a result of a) their concept of the nature of a mental health service function, and b) their expectation that they can be relieved of specific anxieties through the use of the service. Of course, the continued involvement of the referring agency in the case should be an explicit aim of the mental health administrator, who works at many levels with his clinical personnel and agencies, as well as with other community agencies, attempting to develop the partnership approach to the fullest, and who views case collaboration as a basic operation of the partnership.

Roberts has stated that the local mental health administrator's job is to "plan, organize, direct and represent."* Through assessment of need by means of self surveys and epidemiologic study of the population, the program

*Harold D. Chope, M.D., has brought a useful administrator's mnemonic device, "PODSCORB," to the attention of the author: the administrator is concerned with Planning, Organizing, Directing, Staffing, Coordinating, Reporting, Budgeting.

director presents basic facts to an organized community mental health partnership. It in turn develops long-term and short-term goals, develops policy, makes decisions and commitments, and works to coordinate and integrate specific program activities. The local mental health administrator organizes direct services. He is concerned with personnel management, in-service training, budget preparation and presentation, budget control, legal matters relating to patient care, service contracts and forensic psychiatry. In addition he is concerned with program research, planning and development. In his direction of the program, he is concerned with many housekeeping details. He organizes various professional advisory groups. He is concerned with designation of staff duties and responsibilities, and works to minimize role confusion. He reviews experiences, and continually evaluates the results of program activities. When he represents the mental health program at meetings of various professional, lay, and official groups, he represents first, established mental health principles and standards of practice in clinical psychiatry. He also represents the goals of the local mental health program as developed by the locally organized partnership. Finally, he directly represents the clinical services and the mental health education and consultation services of the program.

The local mental health administrator works to translate ideas and hopes into new social and professional practices and programs. His own professional aim is to develop new programs which can become institutionalized systems of services involving many groups and agencies in the community. The success of such activities by a local mental health administrator can be measured by the degree to which the community mental health partnership and mental health services will continue to develop and expand long after the administrator himself has left the scene.

APPENDIX

Source Material

Mental health professionals and community groups no longer need work on a "trial and error" basis in developing new programs. Professional organizations, such as the American Orthopsychiatric Association, the American Public Health Association, and the various professional psychiatric, psychological and social work organizations at state and national levels have organized committees and study groups to deal with community mental health problems. They provide consultant help to those who request it. For instance, the guide to a Community Health Study of the American Public Health Association is available to groups desiring to conduct self-surveys. The Group for the Advancement of Psychiatry has published many reports of value to community mental health practitioners. Complementing the professional associations are the state mental health associations and the parent National Association for Mental Health, Inc., which will provide a number of services to communities including help to organize a local lay partnership organization.

The National Institute of Mental Health has played an extremely vital role in stimulating and conducting research and special studies in the community mental health field. The Community Services Branch and Biometrics Branch are particularly important to community program administrators. A number of universities are now conducting special research and training programs in

this field, and Schools of Public Health are becoming particularly active. Many large national private philanthropic foundations have supported research and development in community mental health. Of special note are the Grant Foundation and the Milbank Memorial Fund which in the past have provided major support for a number of research projects. The Milbank mental health publications should be on the bookshelf of every mental health administrator.*

The reference guide to community mental health and social psychiatry, prepared by a committee and staff of the Harvard-Massachusetts General Hospital Community Mental Health Training Program, has opened the door to a rich body of literature now available on community psychiatry and related topics.[4] In addition, unpublished material in mimeographed form is usually available on loan from state mental health agencies, regional offices of the United States Public Health Service and the Community Services Branch of the National Institute of Mental Health.†

Most mental health administrators are active in the American Orthopsychiatric Association, and many others are becoming familiar with the relatively new Mental Health Section of the American Public Health Association. A National Association of State Mental Health Program Directors was organized recently, and an annual Conference of State Mental Health Authorities is held in Washington to review programs, and advise and consult with the National Institute of Mental Health. However, a national association of local mental health program administrators has not been organized as yet, and many psychiatrists who suddenly find themselves involved in local program administration with no one to "turn to" have become increasing aware of the need for such an organization. Some states have organized state conferences of local program administrators as a partial solution of this problem.

The Council of State Governments has assumed considerable leadership in the past 10 years in the mental health field. For example, it has sponsored several Governor's Conferences on Mental Health, the last in Chicago in 1961. The National Association for Mental Health and the American Psychiatric Association sponsor a Joint Information Service, which prepares material of value to local program directors in their information and orientation program. The Mental Health Materials Center has available for distribution booklets, pamphlets and other materials, and the Mental Health Film Board, among others, will supply cinematographic material to local mental health programs for use in community organization, mental health education and orientation.

*Of course, many other foundations of the dating back to the Commonwealth Fund in the 1920's, have also made major contributions, directly and indirectly to community psychiatry.

†An information clearing house may soon be established by the NIMH.

REFERENCES

1. *Action for mental health.* Final report of the Joint Commission on Mental Illness and Health. New York: Basic Books, 1961.
2. Bindman, A. J., and Klebanoff, L. B. "Administrative problems in establishing a community mental health program." *Amer. J. Orthopsychiat.*, 1960, *30*, 696–711.
3. *Broad integrated program of mental health services in an urban community.* (Proceed-

ings of two workshops in Hartford, Connecticut, Feb. 1, 2, 3, 1961, and Feb. 28, March 1, 2, 1961.) Hartford: Connecticut State Department of Mental Health, 1961.
4. *Community mental health and social psychiatry, a reference guide*, prepared by Harvard Medical School and Psychiatric Service, Massachusetts General Hospital, Cambrdge: Harvard University Press, 1962.
5. Davies, S. P. *Towards Community Mental Health*. New York: The New York Association for Mental Health, Inc., 1960.
6. Dax, E. C. *Asylum to community, the development of the mental hygiene service in victoria, australia*. Melbourne: Cheshire, 1961.
7a. *Decentralization of Psychiatric Services and Continuity of Care*. New York: Milbank Memorial Fund, 1962.
7b. Downing, J. J., and Vaughan, W. T. Early treatment psychiatric services. *Ment. Hygiene*, 1962, *46*, 486–497.
8. *The elements of a community mental health program*. (Proceedings of the Fund's 32nd Annual Conference. New York: Milbank Memorial Fund, 1956.)
9. Ewalt, J. R. A Case fo rthe Community Self-Survey, *Publ. Hlth. Rep.*, 1957, 72, 620–623.
10. ——. *Mental health administration*. Springfield, Ill.: Charles C Thomas, 1956.
11. *Guide to communities in the establishment and operation of psychiatric clinics*, Albany: New York State Department of Mental Hygiene, 1959.
12. Hallock, A. C. K., and Vaughan, W. T. Community organzation, a dynamic component of community mental health practice. *Amer. J. Orthopsychiat.*, 1956, *26*, 691–699.
12a. *Highlights of recent community mental health legislation: Fact Sheet* #8, Jan. 1959, Joint Information Service, APA-NAMH, 1700 18th St., N.W., Wash. 9, D. C.
12b. Hussy, H. R. In *Program for community mental health*. New York: Milbank Memorial Fund, 1957, pp. 78-9.
13a. Klebanoff, L. B., and Bindman, A. J. Development of a community mental health program. *Amer. J. Orthopsychiat.*, 1962, *32*, 119–132.
13b. Dorken, H. Problems in administration and the establishment of community mental health services. *Mental Hygiene*, 1962, *46*, 498–509.
14. Kotinsky, R., and Witmer, H. L. *Community programs for mental health*. Cambridge: Harvard Univ. Press, 1955.
15. *A long range plan for mental health services in California*. Sacramento: California Dept. of Mental Hygiene, 1962.
16. *Mental health teaching in schools of public health*, report of National Conference, Dec. 6–11, 1959, sponsored by Association of Schools of Public Health. New York: Columbia Unversity School of Public Health and Administrative Medicine, 1961.
17. Mitchell, C. F. Community organization for prevention in the texas health department mental health program. Paper presented at Annual Meeting, American Public Health Association, Detroit, Michigan, Nov. 16, 1961.
18. *Programs for community mental health*. (Proceedings of the Fund's 33rd Annual Conference.) New York: Milbank Memorial Fund, 1957.
19. *Progress and problems of community mental health services*. (Proceedings of the Fund's 35th Annual Conference, Part I.) New York: Milbank Memorial Fund, 1959.
20. Robinson, R., de Marche, D. F., and Wagle, M. K. *Community resources in mental health*. New York: Basic Books, 1960.
21. Schwartz, M. S., Schwartz, C. G., Field, M. G., Mishler, E. G., Olshansky, S. S., Pitts, J. R., Rapoport, R., and Vaughan, W. T., Jr. *Social perspectives* on *mental patient care*. To be published.
22. *Short-Doyle Act for community mental health service*. Sacramento: California Department of Mental Hygiene, 1958.
23. Thomas, R. E., and Short, R. P. Some community organization techniques used in the establishment of a comprehensive county mental health program. Paper presented at the 39th Annual Meeting, American Orthopsychiatric Association, Los Angeles, Calif., March 22, 1962.