ORGANIZATIONAL ISSUES IN COMMUNITY MENTAL HEALTH ADMINISTRATION

by

R. DAVID TURNER
B.A., The University of British Columbia, 1964
B.S.W., The University of British Columbia, 1966
M.S.W., The University of British Columbia, 1967

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Department of Health Care and Epidemiology

The University of British Columbia
2075 Wesbrook Place
Vancouver, Canada
V6T 1W5

Date July 17, 1979
Thesis Advisory Committee:

Dr. V.F. Mitchell (Chairman)
Professor
Faculty of Commerce and Business Administration

Dr. A.O.J. Crichton
Professor
Department of Health Care and Epidemiology

Dr. J. Robinson
Assistant Professor
Department of Health Care and Epidemiology
Title of the Thesis: Organizational Issues in Community Mental Health Administration

Name of the Author: R. David Turner

The dissertation discusses the provision and organization of mental health services through the operation of Community Mental Health Centres outside the Greater Vancouver area in the Province of B.C. A derived organizational structure of a CMHC is presented permitting a generalizable discussion of inter- and intra-organizational features and their relationship to administration peculiar to this organization.

A number of propositions are generated regarding CMHC organizational structure and process; these propositions are based on the dimensions identified in the areas of organizational technology, environment and goals. The propositions are applied to a model of management permitting an examination of general areas of management concern. Methods of optimizing these areas are discussed operationally with the intent of facilitating organizational effectiveness in a CMHC.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>INTRODUCTION</strong></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>The Historical Base of the CMHC</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>The CMHC Movement</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Pressures to Develop CMHC's in B.C.</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Developments in CMHC Organization in Canada</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td><strong>ORGANIZATIONAL FEATURES OF COMMUNITY MENTAL HEALTH CENTRES</strong></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>A Delineation of Community Mental Health Centres.</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>The Community Mental Health Centres as an Organization.</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td><strong>A DERIVED ORGANIZATIONAL STRUCTURE OF COMMUNITY MENTAL HEALTH CENTRES IN BRITISH COLUMBIA.</strong></td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Human Service and Medical Model of Community Mental Health Centres</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>A Perspective of Organization Structure (Pugh Model)</td>
<td>16</td>
</tr>
<tr>
<td>Chapter</td>
<td>Derived Structure of Community Mental Health Centres</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>4</td>
<td>FACTORS RELATING TO A DERIVED ORGANIZATION STRUCTURE</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Organizational Goals</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Organizational Technology</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Organizational Environment</td>
<td>31</td>
</tr>
<tr>
<td>5</td>
<td>THE SOCIAL TREATMENT MODEL IN RELATION TO THE CMHC</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Community Mental Health Technology</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Issues Relation to Utilization of the Inter-disciplinary Team</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>The Unified Treatment Approach</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>The Multiple Treatment Approach</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Inter-organizational Features</td>
<td>44</td>
</tr>
<tr>
<td>6</td>
<td>AN OPERATIONAL PERSPECTIVE OF GOALS TECHNOLOGY AND ENVIRONMENT</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Operationalization of Goals</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Operationalization of Technology</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Operationalization of Environment</td>
<td>53</td>
</tr>
<tr>
<td>7</td>
<td>THE CMHC: A CONCEPTUAL ANALYSIS</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Lack of Goal Clarity</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Implications of Technology</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Implications of Environment</td>
<td>62</td>
</tr>
<tr>
<td>8</td>
<td>THE CMHC: INTER-ORGANIZATIONAL RELATIONS</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Importance</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Riverview Hospital</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>Public Health Programs</td>
<td>76</td>
</tr>
<tr>
<td>Chapter</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td>Hospital Programs</td>
<td>82</td>
</tr>
<tr>
<td>9</td>
<td>ADMINISTRATIVE PROPOSITIONS.</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>Administrative Propositions - Technology and Goals</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>Administrative Propositions - Environment</td>
<td>90</td>
</tr>
<tr>
<td>10</td>
<td>SUMMARY APPLICATION OF PROPOSITIONS TO STEERS MODEL</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Strategic Goal Setting</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Resource Acquisition and Utilization</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>Communication Processes</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>Leadership</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td>Decision-Making</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td>Organizational Adaptation and Innovation</td>
<td>108</td>
</tr>
<tr>
<td></td>
<td>Influence of Setting on Administration</td>
<td>110</td>
</tr>
<tr>
<td>11</td>
<td>CONCLUSION</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>Broad Planning Implications</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>BIBLIOGRAPHY</td>
<td>118</td>
</tr>
<tr>
<td></td>
<td>APPENDICES</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>CMHC PROGRAM OUTLINES</td>
<td>123</td>
</tr>
<tr>
<td>2</td>
<td>JOB DESCRIPTIONS MENTAL HEALTH CENTRE STAFF</td>
<td>127</td>
</tr>
<tr>
<td>3</td>
<td>PUBLIC HEALTH POLICY-MENTAL HEALTH SERVICES, 1972</td>
<td>146</td>
</tr>
<tr>
<td>4</td>
<td>ADMISSION CRITERIA FOR INPATIENT UNITS</td>
<td>154</td>
</tr>
<tr>
<td>5</td>
<td>CODE OF ETHICS-COMMUNITY MENTAL HEALTH PROGRAMS</td>
<td>155</td>
</tr>
<tr>
<td>6</td>
<td>MANDATE OF MENTAL HEALTH PROGRAMS</td>
<td>159</td>
</tr>
</tbody>
</table>
# List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Organizational System and Product Goals</td>
<td>59</td>
</tr>
<tr>
<td>II</td>
<td>Characteristics of Various Environmental States</td>
<td>66</td>
</tr>
</tbody>
</table>
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During the past two decades since the first Community Mental Health Centre was developed in Burnaby there has been a relatively rapid expansion of community based services to the mentally ill. The development of more sophisticated technology and a conscious intent to end the "asylum industry" of the 1930's and 1940's has contributed to the existence of 30 Community Mental Health Centres scattered throughout the province of British Columbia. As will be indicated in subsequent discussions these Community Mental Health Centres vary somewhat in composition and structure. The nature of the catchment areas are diverse. However generalizable features do exist. The Community Mental Health Centre of the late 1970's is a complex inter-disciplinary, decentralized service system with diverse levels of accountability and close ties with other human service organizations. Complexity and the rapid development of technology utilized by Community Mental Health Centres since the development of phenothiazines in 1952 is characteristic of the current milieu of Provincial Mental Health Services. New "relationship therapies" and the Human Potential movement have contributed significantly to the activities which are performed by Community Mental Health Centres. Unfortunately, despite the advances achieved technologically during the past two decades, the management of the organizations designed to apply new technologies has been characterized by a marked lack
of development. Feldman (1974, p. 11) states, "While this increased complexity is likely to characterize the delivery of mental health services for a long time to come it has not been accompanied by the necessary administrative expertise."

In British Columbia as in most regions of Canada, mental health services are generally administered by mental health professionals with little experience or knowledge of administration. This is particularly true of the management of Community Mental Health Centres in the Province of British Columbia. The gap between administrative effectiveness and technological complexity is continuing to expand. This problem is difficult to resolve for a number of reasons as discussed by Feldman (1974, pp. 12-13). Firstly, there is little up-to-date literature on administration in mental health. The necessary theory has yet to be adapted to mental health. Secondly, although administrative theory has a good generic base it is largely shaped by factors such as technology and environment which help form the structure which must be managed. Feldman (1974, p. 12) states, "as a result, administration in mental health is different from administration in other fields while sharing a common base. The nature and effects of these differences are little understood and require careful research." The problem is made more difficult in an attempt to operationalize the term administration and define it in a generalizable fashion.

At a generalizable level, mental health professionals are provided with both constraints and contingencies depending on the organizational structure in which they perform their work or exercise their technology. Ricks (1973, p. 241) states:
A reality of working in the mental health professions is that they are extremely intertwined with organizational functions. Treatment takes place in the context of an institution called a clinic, a hospital or a centre. Within the institution there is a range of services with attendant structures for the execution of that service.

As indicated by both Ricks (1973) and Feldman (1974) the effective administration of organizational structure may facilitate more productive goal oriented activities which is desirable in the application of mental health technology.

It is the purpose of this thesis to examine existing Community Mental Health Centre structures, specifically those located outside the Greater Vancouver area in terms of a number of variables.

There is an examination of existing community mental health centre administrative structures primarily as a function of technology, environment and organizational goals. The purpose of this proposal is to provide a base for developing propositions which will be the result of a synthesis of relevant literature, and an examination of prevailing technology, environment and organizational goals.

In a topic as broad and rich as that proposed it is possible to address the subject matter from a variety of perspectives, utilizing diverse frames of reference. There are a number of options which include decisions regarding the degree of specificity and sophistication of the material utilized in optimizing an administrative model. The material discussed must of necessity address both intra and inter organizational dynamics. For the purpose of conceptualizing a consistent thread of discussion throughout this thesis it is the intent to initially provide an "organizational
photograph" of generalizable organizational features which exist in Community Mental Health Centres in British Columbia without reference to a specific target Community Mental Health Centre. The term derived Community Mental Health Centre or (CMHC) is utilized with this in mind.

Initially a brief historical overview of the Community Mental Health Centre movement in British Columbia is provided with particular reference to the movement from custodial to community care in the treatment of the mentally ill. Following this overview there is a relatively brief examination of the Community Mental Health Centres as organizations with specific reference to the people changing and people processing function discussed in Hasenfeld (1974). The third section of the discussion is an examination of the structure of a derived Community Mental Health Centre utilizing a model provided by Pugh et al. (1968). Subsequent to this discussion a review of the literature outlines some of the more definitive studies which address technology, organizational environment and goals. The majority of studies discussed, particularly in the more recent literature, have highly significant implications for the administration of human service organizations such as Community Mental Health Centres. This section provides a partial source of potential correlations among the three factors under consideration and the administration propositions appropriate for a CMHC. This is followed by an overview of the social treatment model in terms of both intra and inter-organizational features. An operational perspective of technology, environment and organizational goals is presented. A summary of the CMHC in terms of a conceptual analysis is linked to inter-organizational relationships developed between a CMHC, Riverview Hospital, acute psychiatric wards and Public Health programs.
The objective of this material is reflect in the final chapter where propositions are generated, based on previous discussion and applied to a model of management functions which optimally will result in a movement of the CMHC toward organizational effectiveness.
Chapter 1

INTRODUCTION

The Historical Base of the CMHC

The early history of mental health treatment and the work of philanthropist such as Dorothea Dix has been well documented in the literature. There will be no attempt to reiterate here the evolution of thought which gave rise to the mental hospital of the early 1940's.

Allodi and Kedward (1977, p. 221) state, "In many ways the situations within the mental hospital remained unchanged until the early 1940's." However, at the beginning of the 1940's modern physical therapies were introduced gradually in Toronto at the Queen Street Mental Health Centre. The utilization of insulin, electric shock and more sophisticated forms of brain surgery led also to increasing interest in social and psychological treatment methods. Tyhurst (1963, p. 3) stated of this period, "A new enthusiasm was present in mental hospitals, general hospitals were beginning to develop psychiatric services and the private practice of psychiatry was becoming well developed."

In 1948 the Canadian Federal Government established a system of Mental Health Grants to the provinces to help inject new life into their programs. Over the next ten years Tyhurst (1963, p. 3) states, "Substantial
progress was made, new buildings, new clinics, improved and increased staff and the development of research programs, all helped establish a new professional interest in mental health." By 1950 the Crease Clinic of Psychological Medicine was established at Essondale, B.C.

Considerable concern was felt during this post-war period due not only to over crowding but also due to lack of staff. Staff training to this point had varied greatly according to discipline and availability of recruits. As early as 1925 the Royal Commission in referring to the mentally retarded stated emphatically "the problem was more educational than it was medical." A training school for nurses was established at Essondale in 1930 coinciding with the first trained occupational therapist. In 1932 a Registered nurse was appointed and accepted as a trained Social Worker.

This initial attempt at providing trained staff was devastated by WWII. In 1942, 56% of the new staff at Essondale had no form of psychiatric training or hospital experience. In 1947, 18 R.N.'s and 44 psychiatric nurses were employed in total at the Provincial Mental Hospital.

It is important to note however that travelling clinics were underway during this period initially including Victoria in 1934. Nanaimo and Chilliwack in 1935. There travelling clinics were an option chosen to provide service to communities lacking in psychiatric resources and to expand the base of the Provincial Mental Hospital.

Staffing problems remained in the 1940's and 1950's. The physician was employed and perceived as the major tool in the treatment of mental disorder. Social Workers usually had some form of a nursing background. Nurses were usually untrained and psychologists were used primarily in areas
related to assessment. There was no training in the area of community involvement. The development of the medical school at the University of B.C. in 1950 further entrenched the physicians' position. Physicians to this point were required to spend a three month training period at McGill University.

There was no inter-disciplinary team orientation during this post-war period due to severe deficiencies in training. The physician or psychiatrist was by default not only the leader of a team but he also exclusively occupied administrative positions as no one else had the appropriate training.

The year 1950 marked the end of what Foulkes (1974) refers to as the "asylum industry." The advent of psychotropic drugs significantly shortened the length of stay of patients at Essondale. Open unlocked wards were established in 1952.

The CMHC Movement

As stressed by Allodi and Kedward (1977) the Community Psychiatry movement really began in the 1960's. For reference purposes CMHC will refer to community mental health centre. This movement was rooted in foundations ranging from the urban settlement houses in the Eastern cities of the U.S. in the 1880's and 1890's, the juvenile court and child guidance movement and the perspective added by Public Health in areas related to prevention was further emphasized in a speech given by President Kennedy in 1963. A U.S. report, "Action for the Mental Health" written in 1961 emphasized the CMHC as a focal point for the network of services. The development of legislative action and the subsequent construction of CMHC is deserving of attention.
In 1949 in the U.S. the National Institute of Mental Health was formerly established and acted for change in American psychiatry. NIMH played an active role in the Mental Health Study Act of 1955. This law directed the Joint Commission on Mental Illness and Health to make recommendations for a national mental health program, federally funded to match local funds with the objection of eventually replacing the customary state hospital programs. The attention commanded by the report and a sympathetic President led to the enactment of laws authorizing funds for the construction of CMHC with necessary operating costs. One umbrella feasibility was envisioned with an inpatient unit, outpatient services and emergency services. The Joint Committee composed of diverse disciplines provided with a strong historic lay involvement in the CMHC movement laid the base for a broad spectrum of services.

A Canadian report, "More for the Mind," written exclusively by psychiatrists and sponsored by the Canadian Mental Health Convention emphasized the development of psychiatric units in general hospital. This report in contrast to the American version did not have as an objective the de-emphasis of services provided by CMHC's. Regionalization was recognized but specific references were made to regional mental hospitals functioning as psychiatric centres. An attempt was made to elevate the status of psychiatry as a specialty within medicine. It should benoted that in general the report placed hospital care of the mentally ill as the best alternative to care over and superior to care through a CMHC. The Report also recommended that services to the mentally ill be provided on the same terms as the physically ill under the Hospital Insurance and Diagnostic Services Act.
In 1959 a major departmental reorganization in B.C. occurred as Mental Health Services was transferred from the Provincial Secretary's Dept. to the Department of Health Services and Hospital Insurance, which had just been formed. Mental Health Services were placed in the same organizational arena as Public Health and Hospital.

In 1959 the Ross Report conducted by the American Psychiatric Association and requested by Eric Martin, Minister of Health Services and Hospital Insurance, recommended a regionalization of mental health districts. In 1967 eight mental health planning regions was established.

Initially the Burnaby Mental Health Centre established in 1961 aided in this regional approach by stimulating demand through regular travelling clinics in the Okanagan and Fraser Valley areas. This assisted in the opening of a Mental Health Centre in Kelowna in 1962. The availability of a psychiatrist for this service also facilitated the rapid construction of a psychiatric ward at the Kelowna General Hospital.

In 1964 the Victoria MHC was constructed and the Vancouver Island Mental Health Centre opened in Nanaimo. By 1966, 10 CMHC's were operating throughout the province, most with travelling clinics stimulating community demand. By 1975 twenty-five CMHC's were functioning.

Administrative problems grew proportionally with the development of CMHC in more remote areas with no access to psychiatric services. The default model of CMHC administration began to develop. Today traveling clinics have largely been supplanted by sub-offices located in the community they serve. They remain administratively attached to an office located in a larger urban area.
From 1960-1967, the Deputy Minister of Mental Health Dr. Davidson facilitated the transition from institutional care to more active psychiatric care of patients admitted in increasing number to acute regional hospitals along with a steady decrease in the occupancy rate of mental hospitals.

In 1967 a review was conducted of the Mental Health Branch which emphasized the decentralization and regionalization of mental health programs through the province.

The following statement was issued by the Government in 1967:

The Mental Health Branch is undergoing a major reorganization to meet the changing patterns of care for the mentally ill and the retarded. It will no longer be primarily service oriented but will assume increased responsibility for the overall aspect of mental health planning in order to facilitate the decentralization and regionalization of mental health programs throughout the province.

An emphasis was placed on the provision of consultation and indirect services to existing agencies. Following the Public Health format, 8 regions were delineated based on school district but unfortunately not coterminous with Public Health boundaries.

In 1968 the regulations of the B.C. Hospital Insurance Act were amended to permit the minutes to designate certain hospitals for day care and out-patient services. In 1969 Riverview Hospital was designated an open hospital available to qualified physicians. This move along with the development of the Eric Martin Institute in 1970 augmented the supply of psychiatric beds.

Pressures to Develop CMHC's in B.C.

Despite these changes the distribution of psychiatrists across B.C. was very uneven. The concept of regionalization was accompanied by a fairly
rapid expansion of CMHC's to fill the gap. This was combined with the increasing utilization of psychotropic medications which helped facilitate the treatment of the mentally ill within their own environment.

Another set of pressures developed when a right wing government led by Social Credit in the late 1960's reacted conservatively to the social disorganization seen in the counter-culture movement. A similar and analogous situation was seen in the actions of a right wing municipal government in the city of Vancouver. An ideology reflected in plicies to control the aberrant behaviour of the "hippies" was seen at both levels of government. A unique program concentrated in the metropolitan Vancouver area, planned by Dr. J. Cumming in 1971 was oriented toward community control of the adult psychotic.

During the past several years the physician has been increasingly encouraged by Medical School and Colleges to play a greater role as a family health manager. There has been continued discussion as to different forms of health care delivery. A multi-disciplinary approach to health, including mental health is becoming pervasive. A need for rational and coherent, treatment organizations is increasingly expressed in the general field of health care. Foulkes (1974, p. 32), states, "At this point in time we have perhaps the greatest paradox of the century that has passed since 1872. On the one hand there is an "organizational imperative" especially in health care. On the other, the dehumanizing influence of the corporate form in business enterprise and the revelation by Galbraith, White, Packard and others of the mechanism of the industrial state, the organization man and hidden persuaders make for fearfulness when the health care "corporation" is contemplated."
This paradox is reflected in British Columbia Mental Health Programs.

Developments in CMHC Organization in Canada

It is necessary at this point in discussing organizational issues in the administration of CMHC's to summarize briefly the default model of administrations which has grown up during the last decade.

An institutional base for the delivery of service in the 1950's predisposed a medically oriented service system with a relatively rigid and prynomidal hierarchical structure. Many of the events referred to earlier in this chapter contribute to this state of affairs. During the early and middle sixties there was a concerted effort to provide psychiatric leadership to the emergent CMHC's which were developing at an increasing pace. Some of the centres in the urban areas managed to achieve this leadership and developed comfortable relationships with the psychiatric treatment institutions. But many were not able to attain this state. Director positions remained vacant for such a period that it was necessary to recruit other disciplines in an acting capacity. Eventually in the early 1970's these acting Director positions filled by non medical professionals were confirmed as legitimate. Friction and problems developed with the medically oriented institutions particularly related to medical tasks such as admissions and renewal of patients' leaves. During the mid 1970's more psychiatrists were added to staffs of CMHC primarily on a sessional basis. Policies reflected a growing recognition that psychiatric time was too expensive to relate to direction and administration. At present there are no Directors of CMHC's in this province who are psychiatrists. Friction and misinterpretations continue with the large institutions.
The implicit power of the psychiatrist remains inculcated in sessional and part-time positions related almost exclusively to high status clinical roles. More than frequently the technology at the disposal of the psychiatrist directly subverts the administrative directions expressed by non-medical personnel.

This issue is further complicated by the impact of a multi-disciplinary team on coherent and integrated management of each unit. As indicated earlier the physician is encouraged in his training to play a greater role as a family health manager. Psychiatric nurses are now enrolled in management programs such as the Community Post-Basic Administration program. Social Workers are extending their familiarity in areas related to supervision. Psychologists are beginning to perceive health care delivery within a behaviourist framework. Frequently incompatible management models coexist within a CMHC and between CMHC's in due geographical proximity.

The objective of this thesis is to rationalize these diverse perspectives by examining in some detail a model of management which has a potential for standardization and generalizability. This model can only be developed by addressing the type of work done in a CMHC, the environment in which that work is done and the goals of the CMHC.
Chapter 2

ORGANIZATIONAL FEATURES OF COMMUNITY MENTAL HEALTH CENTRES

A Delineation of Community Mental Health Centres

At this point it is necessary to examine a representative Community Mental Health Centre as an organization distinct in structure and form from the more traditional models based on industrial forms. Miller (1971) and Mechanic (1973) discuss organizations as social groupings organized around the pursuit of specific goals. At a high level of generality organizations may be considered a collection of parts which interact with each other. There is a general orientation toward the organization of activity which is tuned to the achievement of overall goals. In order that the organization may achieve effectiveness in terms of identified goals, the structure of the organization may take a variety of forms and the collectivity of activity may assume certain functions. It is possible to classify and delineate organizations in a variety of ways, each subject to a degree of criticism. The present concern is primarily the distinctive function operative in the Community Mental Health Centres as organizations.

Burns and Stalker (1961) distinguish between mechanistic and organic organizational forms. Both of these approaches were to a large
measure a function of the relative degree of stability in the environment. Mechanistic systems generally have a greater degree of centralization of control with a higher degree of task specialization than organic systems. Organic systems tend toward horizontal communication rather than vertical and are generally seen as more flexible than mechanistic systems. A Community Mental Health Centre possesses many of the characteristics associated with the organic form which is seen as being appropriate to changing internal and external conditions and unexpected requirements. The required activity of teamwork obviates the functional isolation so characteristic of mechanistic systems. There is an adjustment and a continual re-definition of individual tasks and roles as interaction is consistently high. There is a contributive nature of special knowledge to the common task and a commitment to the task usually going beyond the technical role prescription attached to positions within the organization. Burns and Stalker (1961, p. 346) add:

...organic systems are not hierarchic in the same sense as are mechanistic, they remain stratified. Positions are differentiated according to seniority, i.e. greater expertise. The lead in joint decisions is frequently taken by seniors but it is an essential presumption of the organic system that the lead, i.e. authority is taken by whoever shows himself most informed and capable, i.e. the best authority.

It is believed that this statement by Burns and Stalker (1961) accurately reflects the operative role of the Community Mental Health Centre administrator.

The Community Mental Health Centres as an Organization

During the past several decades there has been a proliferation of formal organizations that are structured to process and/or change people.
Hasenfeld and English (1974, p. 1) state, "This trend on the one hand, demonstrates the shift of socialization and social control functions from primary groups such as the family to the state, and on the other hand it reflects the development of complex people processing and people changing techniques that can no longer be implemented in small social units."

Hasenfeld (1974, pp. 1-30) discusses some of the ways in which a "human service" organization differs from other bureaucratic organizations. Primarily the organizational input is composed of people who have unique characteristics. Contemporary technology transforms this input, resulting in people who have been processed or changed in a predetermined manner. Secondarily in a human service organization such as a Community Mental Health Centre the general mandate is one of "service" that is to maintain and improve the general functioning and well being of people in accordance with the value system held by members of the organization. These two major characteristics of human service organizations are emphasized by Lefton and Rosengren (1966, p. 302) who state:

This transition appears to invoke a major shift in the criteria by which the operations of organizations must be evaluated. That is, the substitution of what may be called 'humanitarian' values for purely economic and administrative considerations will eventually demand organizational responsiveness to an ethic of service rather than one of efficiency.

The issue of social support or social control must be considered in the light of the prevailing ideology of the time. A relatively conservative government such as the Social Credit movement may orient their policies toward efficiency in the control of people rather than be necessarily responsive to the service or humanitarian ethic.
Hasenfeld and English (1974) identify three societal functions performed by human service organizations. Members of society are socialized in preparation for the occupancy of future roles. Secondly, human service organizations serve as institutionalized agents of social control that function by identifying individuals who fail to conform to their role prescriptions. The functioning of societal institutions is thus encouraged to continue without interruption. Thirdly, a social integration function is performed which provides the means and resources for the individual to assimilate with those social units of which he is an affiliate. The integration of the individual into society is facilitated.

If we examine a Community Mental Health Centre in the light of a highly abstracted function and product, Hasenfeld (1972), Vintner (1963) and Whetten and Aldrich (1976, unpublished) suggest that it is possible to delineate the organization as either people processing or people changing. Hasenfeld (1972) suggests that organizations displaying a dominant people processing function are primarily concerned with producing people or output with changed status and locations in various community systems. Vintner (1963) addresses the distinctive features of a treatment organization as being characteristic of a people changing function. He defines a treatment organization as one which seeks to resolve problems of deviance and to change the behaviour of people to permit adequate performance of conventional social roles. It is suggested that a Community Mental Health Centre exemplifies a "mix" of these two functions as stated by Hasenfeld (1972, p. 60), "Moreover, processing functions (i.e. classifying, conferring public status and disposing of clients), are integral parts of the technology of people changing organizations" (e.g. Friedson, 1965; Scheff 1966, pp. 169-187;
Scott, 1969). If one considers a continuum with a people changing function at one pole and a people processing function at the other pole, a Community Mental Health Centre's functional locus is toward the people changing pole (See Appendix 1). A Community Mental Health Centre is involved in people changing activities through the utilization of psychotherapeutic technology on a group and individual basis. Psychotropic medication, a further functional emphasis, is prescribed and dispensed in order to produce behavioural change. A people processing function may be carried out simultaneously or sequentially as patients are certified and/or classified according to clinical definitions of presenting behaviour and either returned to their original social set, directed toward involvement in the people processing function, or rejected through institutionalization. A further people processing function is reflected in the fourth option which involves referral of the patient to a more appropriate resource. It is intended to elaborate and correlate this material with a subsequent section of discussion relating to technology.
Chapter 3

A DERIVED ORGANIZATIONAL STRUCTURE OF COMMUNITY MENTAL HEALTH CENTRES IN BRITISH COLUMBIA

Human Service and Medical Model of Community Mental Health Centres

For the purposes of the present discussion and to facilitate a conceptualization of Community Mental Health Centres, operations in the Province of British Columbia it is useful to bear in mind the distinction made by Schulberg and Baker (1970) between a medical practice model of Community Mental Health Centres operations and a human service model. A structural arrangement comprising the medical practice model is predicated on medical leadership and responsibility. Supervision of virtually all community mental health services may be implied. The human service model, much more representative of Community Mental Health Centres structure in British Columbia, features non-medical administration and a perception of the Community Mental Health Centre as a supportive catalytic resource in which exchange relationships and feedback mechanisms move toward formalizations. Schulberg and Baker (1970) indicate the prevalence of the human service model in rural areas and where programming has a strong social action component. The human service model epitomizes an organic open system with all its attributes and characteristics. Schulberg and Baker (1970, p. 439) state, "For the network to be viable it must be sensitive
to the aspirations and limitations of its component members as well as being aware of the varied ways in which environmental forces impinge upon it." There will be an elaboration of this issue in Chapter 4.

A Perspective of Organization Structure (Pugh Model)

At this juncture there will be an examination of the organizational structure of a derived Community Mental Health Centre currently functioning in the Province of British Columbia. At the onset, however it is necessary to operationalize the term structure which is subject quite frequently to misinterpretation.

A condition of scarcity exists in a CMHC program which is highly labour-intensive. Community mental health systems increasingly must develop interdependencies with their environments. Exchange relationships between Community Mental Health Centres and other organizations are predicated on scarcity of resources. With these factors in mind and recognizing the characteristics distinguishing an organization in terms of collectivity of action it is appropriate to view structure from the perspective suggested by systems theory. The perspective offered by systems theory affords the formal recognition that contextual variables and organization structure are multi-dimensional constructs which interact with each other in a multivariate process. Such a recognition suggests the discussions provided by Levitt (1964), Lievegoed (1969), Katz and Kahn (1966) and Emery and Trist (1975). Blalock and Blalock (1959, p. 74) regard structure as the relationship between elements and state, "Most generally it is a tool used to describe relationships between elements in a system with respect to certain variables, the variables chosen being dependent upon the purpose of analysis."
Regarding structure from the theory base provided by systems theory provides us the added recognition of the time dimension. Miller (1974, p. 38) states:

"The structure of a system is the arrangement of its sub-systems and components in three dimensional space at a given moment of time. It may remain relatively fixed for a long period or vary from moment to moment depending on the characteristics of the process in the system."

Although, Ackoff (1973, pp. 85-98) identifies structure as only one element of the organization, the concept may be regarded as a highly significant factor which will provide a theory base for discussion with respect to the target variables of technology, environment and organizational goals. It is necessary to address organizational structure emphasizing basic structure with less reference to operating mechanisms as discussed by Lawrence and Lorsch (1970, p. 1).

Derived Structure of Community Mental Health Centres

It is necessary to distil a derived organizational structure of a Community Mental Health Centre representative of Centres outside the Greater Vancouver area and contained within the larger structure of Community Mental Health Programs of the British Columbia Department of Health. It is anticipated that this structural analysis will provide the reader with a reasonably accurate picture of Community Mental Health Centres operations at the community level in British Columbia. As there is a primary concern with the development of administrative propositions with an emphasis on staffing patterns and role functions of employees within the derived organizational structure (See Appendix 2). Levenson and Ruff (1970, p. 18) state:
"In many respects each of these centres is unique, for each serves what is essentially a unique community. At the same time, however these centers share many common features. One particularly important group of common features and experiences is that which relates to the development of staffing patterns."

To contain discussion within manageable boundaries a model will be utilized by Pugh et al. (1969, pp. 65-105) which identifies four basic underlying dimensions of structure present in all work organizations and excluding voluntary organizations.

With due recognition to environmental and demographic factors the policy of community mental health program reflects a recognition and acceptance of an inter-disciplinary team approach as a functional method of delivering mental health services within our province. Traditionally, there has been an acceptance of the four core mental health disciplines, psychiatry, social work, psychology and nursing. Pharmaceutical services may or may not be provided by the Community Mental Health Centres largely dependent on the availability and utility of services coexisting in the community, such as hospital pharmacies and their accessibility to the professional and patient population of the area serviced.

Dependent largely on financial constraints and perceived community need, occupational and/or activity therapists may be attached to a Community Mental Health Centre. Usually these positions are sessional in nature, are not public service positions and are funded through other governmental organizations such as the Community Care Facilities Society. Variations in terms of required education and/or experience exists in all these positions and to a large degree are dependent on financial constraints and manpower availability. Community Mental Health Programs policy statements
accept the need for one professional staff drawn from the four core dis­ciplines as being required per/10,000 population. Operationally a Community Mental Health Centre staff configuration for the purpose of our discussion consist of a psychiatrist, psychologist, social worker, nurse, a part-time pharmacist dispensing primarily psychotropic medication on referral. An activity therapist and two clerical staff are included. Such a configuration is considered appropriate in terms of our administrative model and the derivation of generalizable administrative strategies applicable to the operations conducted by a Community Mental Health Centre within the province.

The first dimension to be considered is "structuring of activities" which subsumes the structural variables of standardization, formalization, specialization and vertical span. Pugh et al. (1969) discuss structuring of activities in terms of the degree of specificity of role prescriptions existing within the organization. If one examines the role prescriptions of the four core mental health disciplines provided in (Appendix 2) one is struck by the high degree of abstraction contained in the characteristics of the position. Role ambiguity and role blurring and the tolerance for these states may be regarded as a prerequisite for employment in a Community Mental Health Centre with four to six program staff. Relatively unrestricted intake procedures, the spectrum of human problems covered and the frequent absence of staff from their office locations predispose a relatively low degree of specificity of role prescription (See Appendix 2). Unrestricted intake procedures and small staff size is reflected in both low specificity of procedures to cases and low specificity of tasks to roles. Further dis­cussion in this area will be undertaken when technology is considered.
A second dimension deemed by Pugh et al. (1968) as being significant is that of line control of work flow in contrast to inpersonal control of work flow. In the considered, derived organizational structure, the Community Mental Health Centre may be seen as a heavy and high degree of line work flow control. Whittington (1973, p. 57) states, "...especially in mental health agencies the individual staff member operates with a high degree of autonomy and privacy which defies the imposition of sterotyped, predictable behaviour by any individual in a management position or by any administrative or management system." Each staff member usually considered to be a professional who is capable of functioning with little or no supervision, indeed the term supervision is now largely ignored in favour of the term consultation. Individual staff members have autonomy within the parameters of their operational role to establish waiting lists provided the decision is made in terms of their professional expertise.

A third organizational dimension discussed by Pugh et al. (1968) is designated the supportive component. This factor is primarily concerned with the amount of activity auxiliary to the main work flow of the organization. Operationally in our derived organizational structure this dimension is reflected in non-control supportive activities of clerical staff. For our purposes a Medical Records-Receptionist and a Stenographer are utilized (See Appendix 2). Further reference will be made to this area in the discussion relating to technology.

A final and perhaps most significant structural dimension with a number of implications for Community Mental Health Centres administration is concerned with concentration of authority. Pugh et al. (1968, p. 86) regard this dimension as marked by the opposition of centralization and
Specialization is in the direction of dispersed authority, as would be expected; with more specialization, authority is likely to be distributed to the specialists." As indicated in previous discussions the program staff of the Community Mental Health Centres derived organizational structure consists of four members drawn from four core mental health disciplines, each with considerable expertise and a high degree of specialization despite the pervasive presence of rôle blurring and a degree of substitutability of function. Whittingdon (1973, p. 79) suggests that such a staff configuration predisposes dispersed authority and participation is a transcendent good in itself and that a democratic process is likely to bring positive moral good." It should be noted that disciplinary consultants in the management sector possess linkages to each discipline in the centre within the parameters largely of clinical activity. On occasion authoritative functions may be assumed by the disciplinary consultant but usually this only occurs on the request of the designated administration. Leadership functions in a Community Mental Health Centre are codified at a very high level of abstraction permitting a high degree of flexibility of response by the delegated administrator. The administrator is selected usually from one of the four core mental health disciplines. Officially the selection of an administrator is made by the Assistant Deputy Minister of Mental Health Programs however considerable influence on the decision is exerted by existing staff of the Community Mental Health Centre particularly veto powers. The administrator receives nominal financial recognition with the result that other staff members frequently receive more renumeration in terms of salary than the administrator. Generally the administrator is responsible for developing program parameters. However,
considerable legal accountability is attached to the position, as the administrator is also designated a Superintendent of a Mental Health Facility.

It is appropriate at this point to discuss briefly a derived profile of a Community Mental Health Centre administrator within the context of the inter-disciplinary team. Within the structure which we are discussing, each administrator is selected from one of the four mental health disciplines and carries his clinical heritage to his administrative position. He is subsequently required to maintain both clinical and administrative role functions simultaneously. Perhaps the most apparent and potentially hazardous aspect of Community Mental Health Centre administration is the dilemma of the "Clinician-executive" as discussed by Levinson and Klerman (1967, pp. 3-15). Such a situation is discussed by Herschowitz (1968, p. 1) who states:

"The inexperienced community mental health leader wrestles constantly with his role choices; he must select constantly from his cards of identity and role repertoire a presentation of self which will not be incongruent with the expectations of reciprocal others and will facilitate task accomplishment."

In essence a Community Mental Health Centre administrator is responsible for the orchestration of an inter-disciplinary team in accordance with an attempt to rationalize highly abstracted official goals with the informal goals of the Community Mental Health Centre. These informal operative goals are usually derived from the achievement of some degree of consensus among the diverse professional values and mental health ideologies present in the composition of the team. Not a small task by any manner of means.
The increasing pace and tempo of mental health technologies has caused differentiation and increasing specialization among mental health disciplines. Increasing differentiation implicitly and explicitly predisposes the need for integration embodied in the expected role function of the Community Mental Health Centre administrator. There is an attempt to combat service and professional fragmentation. Selig (1976, p. 18) in a paper discussing inter-disciplinary team leadership states, "The ability to integrate and coordinate different personality styles and technical knowledge and skill are important attributes." As will be discussed in a later section the Community Mental Health Centre Administrator must not only establish goal oriented team activity but also facilitate the maintenance of team activity and survival. Facilitating shared ideologies, reconciling theoretical approaches, decision making, effective communication and matching people with jobs are among the more significant aspects of the role function of the Community Mental Health Centre administrator.
Chapter 4

FACTORS RELATING TO A DERIVED ORGANIZATIONAL STRUCTURE

Organizational Goals

Organizations, definitively may be regarded as collectivities of actions or social grouping which are oriented and developed around the pursuit of goals. Etzioni (1964, p. 32) states of organizations, "They differ from families, tribes and other social collectivities in the extent of their planning, the more limited scope of their goals and the degree of substitutability of their personnel." Organizational goals as expressed in much of the literature have been addressed in terms of the degree to which the organization may be described as effective. Etzioni (1964) refers to this approach as the goal model and draws attention to some of the shortcomings. The system model of organizational analysis refers more to a set of goal activities rather than starting from the goal itself. Etzioni (1964) relates both the system model and the goal model to the means by which the effectiveness of an organization may be assessed. The system model is more concerned with the closeness which an organization comes to optimally distributing resources. It is possible that both these broad approaches may be equally applicable. Robins (1972, p. 210) states, "There
seems to the writer no reason to consider these as mutually exclusive approaches to the analysis of organizational effectiveness."

The current discussion is not primarily concerned with assessing the effectiveness or efficiency of the Community Mental Health Centres but rather is concerned with the optimal administrative style which should be considered given the type of goals of the focal organization. Organizational goals subsume a variety of dimensions and perspectives dependent largely on the purpose to which the term itself is applied, the type of analysis and the goals of the analysis.

Given the space permitted it would seem appropriate to omit a comprehensive review of the literature in terms of the diverse facets and ambiguities implicit in addressing either the system or goal model exclusively. The writer is inclined to address the subject of organizational goals from the perspective of Mechanic (1973, p. 139) who states, "Thus the human relations school emerged with an appreciation that human outcomes were the product of more than merely physical manipulations of the environment." It is not the intent of this discussion to address psycho-social variables directly in the consideration of Community Mental Health Centres goals. Their existence is recognized but it is hoped to distill relatively generalizable features of the goal structure and relate them to an administrative model of relevance to the Community Mental Health Centres structure in the Province of British Columbia.

Administration in Community Mental Health Centres take place within a context which includes organizational goals. Indeed, one may suggest that goals are representative of social and political forces which both constrain and supply contingencies to Community Mental Health Centres
administration. The subject is of considerable importance. It is necessary to address the matrix or field in which goals are embedded and are derived, specifically in the field of health. Blum (1968) suggests the importance of considering the inter-relationship between values and goals. Values are derived from man's need to develop "rules for living" as a result of his need to survive and cope with continuing interaction with his environment. Values predispose a hierarchy of goals in any organization and lay the basis for goal oriented behaviour. In referring to the state of the art of goal definition in the health field, Blum (1968, p. 401) states, "Among the blocks to goal definition are the conflicts between the instrumental values of health and health as an end in itself between quantity and quality, between short run and long run, abstract and concrete goals." Blum (1968), states emphatically that goals must be broken down into more practical sub-elements or dimensions. The dimension selected for study must be consistent with the objective of the study. In this discussion, the achievement of a model describing an administrator's stance is predicated on the verification of the goal dimension selected.

As has been indicated in previous discussion, work tasks and role prescriptions in a Community Mental Health Centre are not rigidly prescribed or specified. Human service organizations are particularly prone and vulnerable to the initiation of personal goals which may or may not be compatible with organizational goals, no matter what the level of abstraction may be or the particular dimension selected for study. Mechanic (1973, p. 147) discusses the propensity for goal dispersal in Community Mental Health Centres and states, "Each of several organizational components may respond to its own situation, emphasize its own needs and emphasize its
own agenda independent of the needs of the whole." In considering the existing decentralized Community Mental Health Centres structure in British Columbia, goal dispersal becomes of significant importance as each centre comes to define crucial issues and priorities on the basis of a distorted picture of the whole. Mechanic (1973, p. 147) continues in his discussion of goal dispersal and states, "Administrative direction is particularly crucial in decentralized units, for each unit tends to only see a piece of the action and comes to define the crucial issues and priorities on the basis of a distorted picture of the whole." It will be suggested in subsequent discussion that goal displacement and the intangibility or tangibility of organizational goals have considerable significance in terms of the required Community Mental Health Centres administration infra-structure.

**Organizational Technology**

The term technology is open to a wide variety of interpretations and its usage appears to vary with the context and purpose of the discussion. There is considerable disagreement on the conceptual definition of technology largely as a result of the researcher's failure to recognize and address the dimensions subsumed by the term itself. Mohr (1971, p. 446) states, "Clearly technology is not in itself a variable but rather only a very broad concept that must become more specific to be useful in research and theory." At the conceptual level the term technology has been treated in a variety of ways. Perrow (1967, p. 194) considers technology as one of the defining characteristics of organizations and addresses technology as the actions which an individual performs on an object in order to make some changes in that object. The object may be a living being, a symbol
or an inanimate object. Georgopoulous (1972, p. 146) related a conceptual
definition to the health care field and states, "We mean to define techn­
ology very broadly as including the characteristics of the inputs, the
characteristics of the transformation activities performed by men or machines
on these inputs and the characteristics of the output." Ricks (1973, p. 242)
addresses technology on a conceptual level in terms of mental health organi­
zations and states, "A technology is simply a collection of activities which
are believed to produce desired outcomes. Examples are such enterprises
as shock treatment, behavioural modification, client centred therapy, etc."

There must be a realization that technology takes place within
the context of a Community Mental Health Centre. Within this context,
attendant organizational structures are established which to a large degree
regulate the execution of the technology employed by the organization.
Perrow (1967, p. 195) in addressing technology on a conceptual level states:

"People are raw materials in people changing or people
processing organizations; symbols are materials in
banks, advertising agencies and some research organi­
zations; the interactions of people are raw materials
to be manipulated by administrators in organizations."

The manipulation of organizational structures by an administrator facili­
tates the control and co-ordination of the technology employed and ultimately
determines the effectiveness of the organization in terms of goal achieve­
ment. Ricks (1973, p. 241) states:

"Everyone knows that these structures are important for
determining the behavior of one's professional activities
and of the type of service received by the client popula­
tion. In turn technology establishes broad parameters of
administrative tactics within the organizational structures
established."
To reiterate somewhat, and as Mohr (1974) suggests, to lower the level of abstraction and further operationalize the term technology; it must be emphasized that a variety of dimensions are subsumed. Litwak (1961) discusses the feasibility of one basic dimension in his reference to task uniformity and the importance of its relationship to organizational work flow.

Woodward (1965) drew attention to the possible categorization of organizations along a scale of "technical complexity." A scale from unit production to mass production of standardized goods suggested an increasing ability to reduce uncertainty and enhance predictability of results. Woodward (1965) limited her study to 300 industrial organizations in England which has been a source of criticism from a number of quarters. Hage and Aiken (1969) reject the applicability of Woodward's findings in terms of their applicability to people processing organizations.

Perrow (1967) derived a similar basic technological dimension to that of Litwak (1961). Basic tasks of organizations were scaled from routine to non-routine. Work flow routines was identified as a basic dimension. In addition Perrow addressed the uniformity of technological transformations occurring in the throughput as being a significant factor in technology. If the organization input is stable and uniform and much is known about the particular technology employed then the organization was considered to have a routine work flow.

Hickson et al. (1969, pp. 378-397) attempted to demonstrate a "technological imperative" in terms of organizational structure but only succeeded in demonstrating the multi-dimensional nature of technology which operates along with other contextual factors in a multi-variate
process with organizational structure. However, they emphasized the importance of work flow integration and appeared to demonstrate successfully that the smaller the organization the wider the structural effects of technology. The closer the organizational structures are located to the work flow the more significant is the effect on technology. Mohr (1971, p. 446) in summarizing Hickson et al. (1969) states of his findings, "However it seems to be largely a measure of the degree of automation or complexity at the system level - a dimension that appears similar to Woodward's."

Hage and Aiken (1969, pp. 366-375) examine the concept of technology in relation to people processing organizations borrowing largely from Litwak (1961) and Perrow (1967). Both Mohr (1971) and Hage and Aiken (1969) recognize the multi-dimensional nature of technology and attempt to derive a general technological dimension. Hage and Aiken (1969, p. 299) examine routines of work flow as a generalizable and basic dimension of technology and state:

The degree of routines is one dimension of technology that can be applied equally to people processing, industrial and other kinds of organizations and it can provide the basis for general propositions that can be tested in many organizational contexts.

Mohr (1971) reinforces this view in suggesting that most of the conceptualizations of technology used in empirical research have been fairly closely gathered around the idea of predictability of work flow operations or routines of work. One must be careful to designate whether work flow routines as a primary dimension of technology is applied to the organization as a whole or to actual jobs performed by individual workers. Mohr (1971), p. 446) states, "For this reason the studies of Woodward (1965), Hickson
et al. (1969), Hage and Aiken (1969) and Perrow (1967) all have a definite relevance for one another."

Organizational Environment

If we continue to view our focal organization, the Community Mental Health Centre as an open system we must of necessity concern ourselves with the matrix or environment which interfaces with the organization. The major difference between a living organic focal organization and that of a non-living closed system is that the former is changed in the course of interacting with its environment and adjusting to their environment and also in such a dynamic process the environment itself is changed. An open system as discussed earlier is characterized by a regular flow of resources from the environment and a continuous outflow of transformed material back into the environment. Feedback mechanisms facilitate the balance in movement of the system. Ricks (1973, p. 243) comments on the Community Mental Health Centres as an open system and states, "Since the environment contacts the organization at both ends of its operation the organization can never be a closed system and therefore it must seek ways of dealing with its dependence on the environment." Ricks (1973) succinctly emphasizes that the technology which is characteristic of the focal system must be monitored to gear itself to the demands of the environment. Understanding the characteristics and needs of the environment of our focal organization is essential in understanding the structure and administration of a Community Mental Health Centre. Schulberg and Baker (1970, p. 441) speak of the importance of environment and state:
The significance of the environment for a community mental health program is widely recognized, regardless of whether the program is organized on the medical practice or human services model and considerable attention is devoted by it to both the geographic community which it serves as well as the other organization systems.

They suggest that administrative flexibility and new technical are required in order to address the growing significance of environment which occurs as increasing emphasis is placed on primary prevention.

O'Brien (1973, p. 169) in speaking on inter-organizational relationships in the mental health field comments on the importance of environment and states, "Thus even where such collaboration does not directly result in the development of new programs, the range of organizational and environmental interaction that occurs will markedly effect how an organization operates."

The term environment has been defined in a variety of ways and is in many ways analogous to the term technology in that it undoubtedly subsumes a variety of dimensions. Dill (1958, pp. 409-443) initially introduced the term task environment which concentrated primarily on those parts of the organizations environment which were deemed relevant to goal setting and goal attainment. The term task environment was also perceived as informational input derived from external sources which is relevant to goal achievement.

Lawrence and Lorsch (1967) also concern themselves with how an organization relates to segments of its environments. They define environment as the information available to administrators which is relevant to the pursuit of organizational goals. No distinction is made between the real attributes of the environment and the administrator's perception of
these attributes. Baker (1973, p. 11) notes that Duncan (1972) is critical of the conceptualizations of Lawrence and Lorsch in that he feels their opinions relate to the perception of the environment as a total entity. In brief the findings of Lawrence and Lorsch (1967) emphasize the importance of a "fit" between organization and environment and suggest that if the organization is to be successful in dealing with its environment, internal system processes must be consistent with environmental demands.

Emery and Trist (1967) appear to have made a significant impact in the conceptualization of organizational environment relative to the field of Community Mental Health. Both O'Brien (1973) and Schulberg and Baker (1970) appear to be comfortable in relating the Community Mental Health Centres to the four fold typology developed by Emergy and Trist. In essence Emergy and Trist (1967, pp. 21-32) introduce the concept "of causal texture" to refer to processes and inter-dependencies occurring within the environment of an organization. The first type is regarded as a placid randomized environment which is characterized by very little connection between the past of the environment. A second idealized environment is regarded as "placid clustered" in which "goods" and "noxiants" are relatively unchanging but are clustered. Thirdly the disturbed reactive environment is characterized by similar organizations competing for similar "goods" in the environment. A turbulent environment is seen as developing from the interaction of organizations in the field but also the field itself is in motion. Both these processes contribute to turbulence. All four ideal types require an organizational strategy and differ in terms of the degree of predictability or uncertainty which confronts the organization as it attempts to maintain its balance in movement. Terryberry (1968, pp. 519-613) emphasizes the uncertainty of some organizational environments
and suggests that organizations are increasingly finding themselves in turbulent field conditions which exceeds the organization's capacity for prediction. New mechanisms such as environmental or systemic monitoring units assume increased importance as there is a striving to reduce uncertainty by the organization.

Gabarro (1973, pp. 196-215) points out that if environments change, the patterns of organizational structure must also change in order to remain effective in terms of goal attainment. Strategies by which the organization relates to its environment are discussed. These strategies will be operationalized in a later section.

Gabarro (1973, p. 196) refers to the studies of Dill (1962), Emery and Trist (1965), Lawrence and Lorsch (1967), Thompson (1967) and Jerryberry (1968) and states, "The dominant theme in these studies is that some patterns of organization and behaviour seem to be more appropriate to certain environmental and task characteristics than others."

In a concise attempt to operationalize environmental concepts and facilitate empirical research, Duncan (1972) examines the components and dimensions of environment. A distinction is made between an internal organizational environment defined as those relevant physical and social factors within the boundaries of the organization which are taken into consideration by decision makers and the external environment which refers to physical and social factors, relevant and occurring outside the organizational boundaries. Further reference to this definition will be made in a later section. Duncan (1972, p. 315) extracts two basic environmental dimensions and states of the first dimension:

The simple part of the simple-complex dimension deals with the degree to which the factors in the decision
units environment are few in number and are similar to one another. The complex phase indicates that the factors in the decision units environment are large in number.

The second dimension, that of "static dynamic" refers to the degree to which factors of the decision units internal and external environment remain similar over time or are in a continuous process of change. Duncan (1972) indicates that the degree of uncertainty which confronts the organization is highest under dynamic complex environmental field conditions and suggest this specific funding is consistent with the theoretical material provided by Thompson (1967), Terryberry (1968) and Emergy and Trist (1965).

Jerkovitch (1973, pp. 380-393), presents a core typology of environmental types. Consistent with the literature mentioned earlier he suggests that different types of environments have implications for those individuals responsible for the planning of strategies, operations and tactics. The work of Jerkovitch will be discussed more thoroughly and operationally in a later section.

Schulberg and Baker (1970, p. 443) in discussing the importance of organizational environments state, "As a result, pressure is being directed toward the mental health system to reorganize its structure and to realign its priorities. Administrative flexibility and new technical competencies will be required to meet changing environmental demands."
Chapter 5

THE SOCIAL TREATMENT MODEL
IN RELATION TO THE CMHC

Community Mental Health Technology

In this section, it will be necessary to address the concept of technology; lower the level of abstraction, and address the social treatment model. Ricks (1973, p. 22) states, "Organizations are formed around various technologies and, in many respects, the nature of the technology and the criteria by which it is judged, determine the structure of the organization." Mental Health organizations, such as CMHC's, by virtue of their interdisciplinary composition and the diverse schools of thought embodied in each discipline passes or have access to a variety of technologies which are utilized, or have the potential to be utilized, in the organizations' movement toward individual and collective organizational objectives. Behaviour modification, insight-giving theory, client centred theory, group theory, chemotherapy — all these examples of technology may be present and available for utilization. Consultation and support provided by disciplinary consultants and others, provide a further source of technology related to such things as innovative ideas, which may generate the more effective utilization of existing technology, assist in the revision of new method or ways of working within the objectives of the CMHC.
It is necessary, in this section also, to examine the importance of how technologies operative in CMHC's, must be aligned with environmental demands consonant with the objectives of the organization. One may suspect that the administrator's role function must address this alignment and possibly monitor changes in the surrounding organizational environment, changes occurring in the type of technologies utilized and the methods in which they are applied to the patient which form the input and raw material of the system. In other words, one of the areas of prime concern must relate to the identification of the appropriate administrative position or stance which will maintain, enhance or improve the technology available to move the organization toward the identified objectives. Administration governs the utilization of technology.

To a large extent, the harnessing of technology available in a CMHC, given the relatively autonomous and decentralized structures existing in B.C.; depend upon the attitude expressed by the administrators. A statement by Greenblatt, Sharaf and Stone (1971, p. 44) reflects this statement when they state, "a decision about the basic philosophy of treatment usually contains a number of other implicit or explicit decisions about other competing treatments about which staff members are best equipped to carry out preferred modes of treatment and about what kinds of treatment." Cumming and Cumming (1967, pp. 107-134) also emphasize the importance of this discussion when they address the problem of authority and how its alteration may influence the ego building process in the patient contained within the structure of the system.
Issues Relation to Utilization of the Inter-disciplinary Team

Inter-disciplinary teams are now a relatively well accepted method of delivering mental health care. The ideologies related to health care are in a state of change. There is no longer talk about sickness and medicine, instead discussion about health, wellness and prevention are more apparent. Medical care may be merely "symptomatic" treatment if we ignore such factors as environment, pollution, media and the increasing anomie seen in high rise development. Comprehensive responses to a comprehensive problem are required. With the rapid development of technology in Mental Health, specialized and technical fields have developed in order to keep up with emerging findings. There has been a proliferation of specialized fields within existing disciplines. The technology related to neuro-psychology is now an occupational sub-speciality within clinical psychology, as administrators are required to specify the "type" of psychologist included in the treatment team. With increasing differentiation the need for the integrative skill of the CMHC administrator also increases. Diversity of disciplines are required to reach an objective which has a base of multi-causation. The inter-disciplinary team is now regarded as an acceptable, indeed inevitable method of relating to a problem which has a multiple etiology. Selig (1976, p. 10) states, "As previously indicated, a basic assumption underlying the rationale for the development of teams is that the specialized knowledge of any one professional is no longer sufficient to solve the problem confronting us. A more shortened way of expressing it is that a systems approach is necessary." The administrator must address this assumption and work toward productive conflict management through shared decision-making oriented toward a productive conflict management through shared
decision-making oriented toward a process of compromise or consensus. An administrative technology, designed to make more equal the skills of diverse disciplinary representatives is required in order to address the increasingly sophisticated and multi-faceted problems of delivering mental health care.

Team delivered mental health care explicitly accents the philosophy of the utilization of diverse technologies in working toward organizational goals. A representative interdisciplinary mental health team is a group of people with fairly specific tasks which require inter-dependent and collaborative effort of all members. The sharing of space and physical proximity does not create team based mental health care. A conscious administrative posture must be adopted and maintained. Rubin and Beckhart (1974, p. 316), emphasize a primary issue in the delivery of health care when they state: "No one member of the team has been trained to be knowledgeable in all the areas required. . . . The anxieties and frustrations are inevitable - an inherent part of providing care." An administrative posture which accepts the philosophy of diversity will quickly recognize the necessity for the team to examine how it will work.

Rubin and Bechart (1974, p. 103) states, "In any case, community health care institutions should develop a compatibility for helping delivery teams conscientiously work on improving their own internal effectiveness through working on their internal processes and relations." Inter-disciplinary teams in the mental health field, operating in small ambulatory care centres, possess considerable role ambiguity as several members may perform the same functions for different patients. Role expectations are unclear, as one team member's knowledge of other team members' 'technological expertise' is usually vague and unclear. Goal priorities are frequently conflictive
among team members as colleagues with different information and skills must, in many instances, achieve consensus or compromise in decision making. These issues, and others, must be addressed by the administrator of a CMHC as it facilitates team examination of such factors as: who does what work?, how will this be decided? what are the role expectations of each member for the other? Other issues may initiate an examination of the personal and professional development needs expressed by individual team members.

A high level of tolerance of ambiguity as to role functioning may be seen as necessary under certain circumstances where an appropriate response to a rapid environmental change requires flexible innovative action in order to achieve the goals of the organization. The absence of the team members on an irregular basis, in a small centre, may require a degree of role substitutability as one team member, where the modality of treatment is unique, may be forced to accept and apply the rudiments of a conflictive treatment modality. An example is seen as a social worker assumes the responsibility for monitoring patients who require psychotropic medication. If the social worker approves an organic method of treatment, his actions may violate his sense of integrity.

Rubin and Beckhart (1974, pp. 121-124) addresses and summarizes two major organizational implications related to the application of multiple treatment modalities in terms of the management of community based health care. Initially, the issue of "reference groups" as collaborative team work must be achieved. Psychiatric nurses may find it difficult to discuss cases with psychiatrists due to their attitudes toward their own competence. A reduction in information flow may occur with little challenging of ideas and low level compromise effected. Administrators must facilitate an
articulation of organizational objectives and the validity of each team member's contribution in moving the system toward these objectives.

A second issue is that of multiple loyalties. If one examines the implications of physician membership on a treatment team, it is necessary for a role definition to be applied, either by team consensus or by fiat. The needs to conserve the resources of the physician requires the recognition that other treatment team members may have a legitimatized right to provide certain services. This legitimatization tends to further the problem of "reference groups" referred to earlier; as a paraprofessional is embedded in both a disciplinary value structure and the norms and values of the organization. Often, these two frameworks appear incompatible to the team member which precipitates involvement by a CMHC administrator as he attempts to relate all team members to the primary objective of patient care.

It is the task of this discussion to address an aspect of the work employed by inter-disciplinary teams with reference to the most effective stance in terms of identified organizational goals.

The Unified Treatment Approach

An administrator of a CMHC may, according to his treatment philosophy, further the development of multiple modalities or technologies or attempt to provide a unified approach to the people changing function of the organization. An administrator who fosters an ideology emphasizing psychodynamic constructs may, through the exercise of social mileau therapy, utilize the total hospital or clinic environment or vehicle for patient change. Role diffusion and an emphasis on staff equality enters the ascendancy.
Cumming and Cumming (1967) appear to be strong proponents of this unified approach; to the point where they suggest an administrator of a psychiatric hospital should delegate complete autonomy to the ward physician in his work toward a total therapeutic environment.

One of the major criticisms of the unified approach to the utilization of treatment technology is the need for clearly defined leadership. Cumming and Cumming (1967, p. 125) state, "Firm and unambiguous leadership seems essential in dealing with the mentally ill; the goal is to get the patients to solve their own problems, not to involve them in deciding the policy of the hospital." As indicated in Appendix 2 and the discussion related to the derived organizational structure of a CMHC; the criteria for successful administration in our context is the individual's tolerance for ambiguity. However, there are definitely some clear advantages to the unified approach. Greenblatt, Sharaf and Stone (1971, pp. 46-47), suggest that one particular technology or treatment modality may be expressed and utilized more effectively. Another advantage stressed is the avoidance of staff discard and the self-selection of a group of heterogeneous individuals. This may also be a disadvantage as there should be more recognition of the positive and constructive nature of the conflict process.

The rapid development of psychiatric technologies as seen in the human potential movement and the ever increasing availability of mood altering drugs, would tend to make one think twice about an administrator who would adopt this type of stance to the exclusion of all others. An organization subscribing to this approach may well run the risk of losing its organicity, as attributes of a closed organizational system come into evidence.
The Multiple Treatment Approach

The administrator may bring to a CMHC a philosophy which would encourage the application of multiple treatment modalities, or in some cases, the facilitation of technologies which may have similar objectives, but conflicting methods by which their agreed upon objectives are achieved. Ambiguity becomes potentially destructive. This approach is stressed as being more rational by Greenblatt, Sharaf and Stone (1967, p. 47) who state, "No single ideological position can possibly serve, either to guide our future adequately in view of our massive ignorance about the etiology and disease process of mental illness or to encompass the advances that have been made in other fields such as biology, sociology and education." If one examines the functioning of a CMHC in the Province of B.C. there would appear to be a policy commitment to the principle of diversity. The principal therapist concept actively encouraged in a majority of Centres does not explicitly favour one occupational group over another. The source of administrative staff may rest in any one of a number of diciplines.

It is felt that the multiple treatment modalities approach argues for the realization of the creative potential of the staff members of the clinic. An administrator, tolerant and supporting of diverse technologies does not explicitly favour one occupational group over another. The avoidance of a treatment or technological hierarchy is actively expressed; encouraging staff to recognize the flexibility necessary in coping with a relatively unpredictable client population. In a sense and from a philosophical point of view, a commitment to the compatability of diverse technologies recognizes the increasing ambiguities of contemporary psychiatry. A single unified approach may inspire staff with a false sense of structure and purpose.
The difficulties of running a large heterogeneous organization are to some extent avoided when the very heterogeneity may further the objectives of the CMHC, both in terms of the goal of the individual, but also those of the organization. This situation of diversity of technology is experienced by the CMHC disciplinary treatment teams currently relating to the population of B.C.

Inter-organizational Features

To this point we have discussed, at some level of generality, the implications of the social treatment model and a number of issues related to the diverse technologies employed by inter-disciplinary team members. This discussion to the present has looked at suggested administrative position.

As has been indicated earlier, a CMHC constitutes an open system which recognizes a flow of energetic material entering, being processed and leaving the organization. The technologies employed by the CMHC are embedded in both an intra-organizational and inter-organizational environment or climate. The effectiveness of these technologies are subject to the efficacy of the administrator in terms of aligning the technologies with the demands expressed by significant systems in the environment of the organization. The relationship between organization and environment be discussed within the context of the interdisciplinary nature of the social treatment model. In order to provide an articulate and coherent picture of the CMHC and the technology employed, it is necessary to emphasize a statement by Lefton and Rosengren (1966, p. 302) who state,
"In addition, the existing conceptions of organizations may have to be broadened to cope with the interorganizational demands engendered by large-scale action programs in the field of human welfare."

The effective utilization of the technologies possessed by members of the interdisciplinary team may be weakened or enhanced by the relationships existing between the CMHC and the community which it serves. Greenblatt, Sharaf and Stone (1971, p. 23) provide an example germane to our examination of a CMHC when they state, "For example, training programs for personnel can be enlarged and improved if positive relationships have been established with institutions of higher learning. In short, favourable change in an institution is dependent on the fusion of two worlds — one within and the one without."

This relationship between organization and environment is dependent according to Steers (1977, pp. 95-99) on three critical variables which determine the impact of organization-environment relations on organizational effectiveness. These three factors are: (1) the degree of predictability of environmental states; (2) the accuracy of perception of environmental states; and (3) the notion of rationality in organizational actions.

If we examine the environment of a CMHC we may perceive it as possessing varying degrees of uncertainty. The degree of uncertainty lies in the predictability or certainty of future events being anticipated accurately by the administrator of the CMHC. Effective planning procedures are dependent on the degree of uncertainty present in the environment of the organization. The ability or capacity of a CMHC to effectively apply technologies consonant with environmental demands and organizational objectives is facilitated to a large extent by the administrator's ability to know what
the environment is going to be like in the future. The more certain the future the more the opportunity to respond appropriately. The response of the organization may be in terms of increasing or decreasing the amount of differentiation and integration. Steers (1977, p. 97) states, "Recent research would indicate that if the environment is highly unpredictable, a more organic structure may be more effective, and a mechanistic structure may be more effective and appropriate for predictable environments."

A second point discussed by Steers (1977) relates to the accuracy of the perceptions of the administrator as he scans the environment. An accurate perception of the organizational environment facilitates an appropriate response and furthers the possibility of a positive relationship between organization and environment. Perceptions of environment are "filtered" selectively according to the individual's work experience, academic training and orientation and the degree of identity and integration with one's professional associations. The dilemma of the clinician-executive occurring among administrators of CMHC as mentioned earlier by Hirschowitz (1969) is a good example. The perception of an environment by a clinically oriented administrator may be quite contrary to that expressed by an administratively oriented clinician. The ethic of service in relation to efficiency may become confused. Steers (1977, p. 97) states, "If on the other hand, an organization enacts an unrealistic environment (either through managerial myopia, lack of expertise, insufficient time, or whatever) the negative effects on organizational success could be substantial."

A third factor which may affect the relationship between the CMHC and its environment is related to the rationality expressed by administrators. Due to inability to process all information or a lack of sufficient
information related to a decision, most administrators respond, according to Steers (1977, p. 98), by using some form of "bounded rationality." Decisions related to organization-environment relations in particular may be optimized rather than maximized.

In summary, Steers (1977, p. 99) states, "Only when accurate perception and high rationality of decision-making are present, then, would we predict that an organization's response to environmental conditions would be optimal, thus contributing to effectiveness."

Greenblatt, Sharaf and Stone (1971, pp. 23-41) discuss in a relevant and tangible manner some of the effects that organizational environment can have on the quantitative and qualitative aspect of technologies employed in an organization such as a CMHC. In a highly labour-intensive industry such as community mental health, a great deal of the people changing functions are predicated on the availability of staff possessing the appropriate skills to perform the work required. This, combined with a rigidly circumscribed government budgetting system based on object categories in a line budget, creates a dependency on a variety of additional non-governmental funding sources for the support of community based mental health programs. The participation of the entire staff in educational campaigns through the primary work of lay groups in the community can often increase the supply of funds to maintain and enhance the functioning of interdisciplinary team members. It is suggested that joint team participation in programs related to fund raising enhances the successful application of the treatment technologies employed by the Centre in terms of both personal and CMHC objectives. Granblatt, Sharaf, and Stone (1971, p. 28) state, "With the shared responsibility of raising money for their hospital, staff will soon learn 
the art of co-ordinating ideas with funding agencies. For example, an innovative program that offers an alternative to hospitalization is likely to interest the federal government and at the same time an enterprising idea in half-way houses or summer camps can capture the imagination of private citizens and so forth." The phenomenon of multiple treatment modalities occurring internally in the organization may also be seen in the environment. A similar pluralism occurs as the administrator supports a diversity of efforts and orientations on the part of the environment in which the CMHC is located.

A further factor, environmentally related, which may enhance and affect the impact of technology is the relationship between the CMHC and local colleges and universities which train the interdisciplinary team members. Diversity in the application of technology and the generation of innovative and creative programs are often stimulated by intern programs and the provision of joint workshops. Reciprocal consultation in the areas of both direct and indirect service has the potential to provide access to new and technologically important information increasing the efficacy of treatment technologies employed by CMHC's. Research collaboration is also a significant feature in the technological implications of the relationship between CMHC's and institutions of higher education.
Chapter 6

AN OPERATIONAL PERSPECTIVE
OF GOALS TECHNOLOGY
AND ENVIRONMENT

Operationalization of Goals

Discussion related to the goals of a derived CMHC, provided little differentiation in terms of the goals of treatment theory within the social treatment model and the literature pertaining to organizational goals. Treatment goals in a people processing organization coexist and reciprocally influence organizational goals. In order to address the more significant issues related to the administration of CMHC's on an operational basis, it will be necessary to outline some of the more salient points of departure.

The goals of human service organizations in the broadest sense are notoriously multi-faceted and ambiguous. The application of a conceptual framework designed to determine organizational goals from an external vantage point may result in a substantial deviation from what is actually occurring in reality. Mechanic (1973, p. 142) states, "Professional organizations, and those in particular that are service oriented, tend to develop rather rich and varied informal networks that may be more indicative of daily activities than the usual descriptions of these organizations would suggest."
The goals of a CMHC encompass a number of functions, including the ten programs specified and defined in Appendix 1. Other CMHC's in North America usually include some variations of the same functions. Mechanic (1973, p. 143) continues in the same vein as above and distills a very salient issue when he states, "These functions would be difficult enough under the best of circumstances, but problems are compounded by the absence of agreed upon technologies, by differences in ideology among varying professional groups, by differences in basic intervention approaches and by continuing situational pressures involving community support, funding, staffing and the like."

Staff commitment to unique and frequently diversified ideologies about the nature of their work predisposes an administrative stance which suggests a mediating role comprised of nurturing organizational movement in new directions and a commitment to identified organizational goals. Treatment goals both on a disciplinary and individualized basis coexist and often are perceived as mutually contradictory in terms of organizational goals.

CMHC's are particularly susceptible to the incorporation of treatment goals. In the rapid growth of CMHC's and the possibilities for new role definitions of an increasing diversity of paraprofessionals, one may observe a great amount of role modification as staff and disciplines proceed to test out new relationships and at first tentatively begin to "carve out" new territories of work relative to other groups in the organizational environment. As the CMHC progresses from a medical model to a social treatment model and more non-medical staff such as Activity Therapists, Occupational Therapists, etc. become involved, the identification of power and authority figures may become more difficult. The potential and opportunity for the incorporation of personal goals related to treatment increases as
increasing negotiation and role construction occurs. Mechanic (1973, p. 146) states, "Such negotiations provide creative possibilities but they also provide opportunities for chaos and conflict and the particular outcome may very well depend on the extent to which there is a coherence of administrative perspective and the nature of power relationships in the community. The issue of administrative coherence is frequently complicated by the problem of controlling external environmental pressures on the organization.

Community groups in a position to demand service frequently voice militant requests for the control of deviance on a community-wide basis. Unrealistic demands in terms of time resources, knowledge and technology are frequently present. A fragmented approach often develops as the CMHC in a disjointed incremental manner permits considerable role expansion of personnel in order to address pressing demands. Treatment goals often maintain ascendancy with a relative disregard for organization directions and broad organizational goals.

Perrow (1967, pp. 195-208) discusses the nature of system and product goals and relates the term system goals to those characteristics of the system as a whole, independent of its product. Steers (1977, p. 24) redefines slightly and emphasizes that the term relates more to the state or manner of functioning of the organization. Modes of organizational functioning such as growth and stability are stressed. The degree of structuring of modes of functioning is also subsumed by the term system goals.

Product goals, as the term implies, relate primarily to the characteristics of the products the organization decides to emphasize. Steers (1977, p. 25) states of product goals — "an emphasis upon quality or quantity, variety, styling, availability, uniqueness or innovativeness of the product."
Operationalization of Technology

In order to facilitate an examination of organizational technology with specific reference to Community Mental Health Centres it is necessary to distil a dimension which is reasonably generalizable and applicable to a cross section of the organizations under study. It is recognized that the term technology is more of a concept than an operationally viable variable. As has been mentioned in subsequent discussions an examination of Woodward (1965), Perrow (1967) and Hage and Aiken (1969) reveal a common emphasis on predictability and control of operations as a significant dimension when considering relationships to features of organizational structure. Perrow (1967, pp. 194-198) suggests the importance of ordering the basic tasks of organizations from routine to non-routine and examining the throughput within the context of work flow uniformity. Litwak (1961) in an earlier paper laid much of the basis for this emphasis. Hickson et al. (1969) attempts to verify the sweeping "technological imperative hypothesis but concludes technology is only one of a number of factors which relate to organizational structure. However in reviewing the literature and attempting to identify a salient and quantifiable variable one is impressed by the statement of Hage and Aiken (1969, p. 299) when they state, "The degree of routines is one dimension of technology that can be applied equally to people processing, industrial and other kinds of organizations and it can provide the basis for general propositions that can be a related remark made by Mohr (1971, p. 446), "Thus more of the conceptualizations of technology used in empirical technology-structure research has been fairly closely gathered around the idea of predictability of operations." Mohr (1971) adds a caution that it is necessary to note whether the dimension is applied to
the system as a whole or to the actual jobs performed by individuals operating within the organization.

Technology is discussed here within the schema provided by Perrow (1967) and Hage and Aiken (1969). The definition of technology provided by Perrow (1967, p. 195) will be used when he states, "By technology is meant the actions that an individual performs upon an object with or without the aid of tools and mechanical devices in order to make some change in the object." Hickson et al. (1969) identify this definition as applying to "material technology" when there is a concern with the characteristics of the material in the work flow. There will be a discussion of the routines of work occurring within a Community Mental Health Centre. Hage and Aiken (1974) and Perrow (1964) defined and measured technology at the individual task level by asking individuals about their work and aggregating their responses to obtain a score. Perrow used a questionnaire while Hage and Aiken utilized structured interviews.

Operationalization of Environment

It may be said that CMHC's depend for their growth and survival on the existence of exchanges with the surrounding environment. In addressing the term "environment," we are again confronted with a multi-dimensional concept, from which we must extract a salient, quantifiable and reasonably generalizable dimension. The dimension selected must, of course, have import in terms of suggested administrative postures. A recent definition selected by Steers (1977, p. 314) emphasizes the importance of the environment of organizations when he states assertively, "A second critical dimension for organizational success is the task environment."
A number of definitions are available which may be appropriate to the task at hand. Duncan (1974, p. 314) differentiates between internal organizational environments and external environments, and defines environment as a workable concept when he states, "Environment is the totality of physical and social factors that are taken directly into consideration in the decision-making behaviour of individuals in the organization." A distinction is made between the internal and external environment of the organization. We are concerned in this discussion with the external environment which is defined by Duncan (1974, p. 314) as "those relevant physical and social factors outside the boundaries of the organization or specific decision unit that are taken into consideration. The introductory definitions are of course at a very high level of abstraction.

Steers (1977, p. 85) identifies three ways in which it is possible to conceptualize an organization's external environment. The first approach, possessing little practical utility, involves defining the environment as that which remains after one defines the boundaries of the organization. Many authors (e.g. Starbuck, 1975) cast considerable doubt as to whether it is possible to define these boundaries. A second approach focuses on viewing the environment as a task environment, or what Steers (1977, p. 85) refers to as "that portion of the total setting which is relevant for organizational goal setting and goal directed activities." Considering the anticipated generalizability of the writer's discussion, this approach may be regarded as somewhat restrictive and specific to certain identified catchment areas.

The third approach is perhaps more germane and generalizable within the parameters of this study. Steers (1977) suggests that this approach is perhaps more abstract, but generally the approach is represented
by: Duncan (1972), Emergy and Trist (1965), Terryberry (1968) and Thompson (1967). These writings possess a common thread which must be articulated. We are concerned with basically the degree of certainty or uncertainty with which organizations can make decisions regarding current and future functioning. Two major dimensions are identified which contribute to environmental uncertainty: a simple-complex dimension to the organizational environment and a static dynamic component. It is necessary to add with caution, as stated by Steers (1977, p. 87), "Moreover, it has been pointed out that one dimension can at times affect the other dimension as both influence an organization's capacity to adapt and respond successfully to environmental stimuli." To reiterate the goals of this study, we are concerned with categorizing the environment of a CMHC in order to make suggestions regarding the appropriate administrative structure in terms of achieving the organization effectiveness.

The simple-complex dimension raises questions regarding the simplicity or complexity of the organizational environment. A simple, or what Emery and Trist (1965) refer to as a placid environment, is one in which the external factors which an organization must deal with are few in number and relatively homogeneous. The more the number of factors and the greater the heterogeneity, the more complex an environment becomes. Steers (1977, p. 86) states, "The degree of environmental complexity can have a significant impact both on organizational behaviour and on organizational effectiveness." Duncan (1972, p. 315) assists in the operationalization of the dimension when he states, "The simple part of the simple complex dimension deals with the degree to which the factors in the decision unit's environment are few in number and are similar to one another in that they
are located in a few components. The complex phase indicates that the factors in the decision unit's environment are large in number."

The static dynamic dimension must also be considered in order to assess the degree of environmental uncertainty and develop hypotheses regarding an administrative position which is predicated on environmental "typing." This dimension considers the relative degree of stability in organizations' environmental relations. A further remark by Steers (1977, p. 87) is relevant when he states, "Environments that are in a constant state of flux often require different organizational structures and approaches to management than do more static predictable environments." A statement by Duncan (1972, p. 316) contributes to the operationalization of the static dynamic dimension when he states, "The static dynamic dimension indicates the degree to which the factors of the decision unit's internal and external environments remain basically the same over time or are in a continual process of change."
Chapter 7

THE CMHC: A CONCEPTUAL ANALYSIS

Lack of Goal Clarity

An examination of the goals of an organization such as a CMHC may assist in providing an additional frame of reference or perspective from which to understand organizational structure. A previous discussion has outlined some of the rationale for an examination of a CMHC in terms of system and product goals. A system goal may be regarded as those objectives which tend to facilitate the organization retaining its identity and integrity. A system goal may be a factor such as morale which is a consideration when considering system integrity. Product goals relate more to the output of the system. In the case of a CMHC, a product goal may be the quantity of patients treated on the quality or the treat delivered. Perrow (1967) identifies a third category of goals which are referred to as derived goals. This type of goal relates more to the power generated by organizational activities which are independent of system or product goals. Organizational attitudes toward government and political philosophies may be seen as examples of derived goals.

It is the intent to relate this rather gross delination of organizational goals to the dimension of technology under study, namely that of
work flow routineness or uniformity. It is important to emphasize at the outset that the discussion is meant to suggest the manner in which goals are shaped or constrained through the influence of technology and structure. There will be not attempt to specify that technology explicitly is directly responsible for the formation of designated goals.

Perrow (1967, pp. 202-203) and Hage and Aiken (1969) discuss the relationship of technology, specifically work flow routineness and the typology of organizational goals outlined above. If we accept the rationale provided in an earlier discussion and designate the work flow in a CMHC as being relatively non-routine, a number of implications are suggested. Perrow (1967, p. 202) states, "We would expect completely routinized organizations to stress those system goals of organizational stability, low risk and perhaps high profits or economical operations rather than growth. In terms of product characteristic goals they would be more likely to emphasize quantity rather than quality, stable lines over unstable or diversified lines, superficial transformations (e.g. instilling discipline in deviant client) over basic transformations (such as character restructuring) and so forth." In contrast, the non-routine organization will emphasize growth quality and innovation being generally less concerned with making profit. Although these relationships suggested by Perrow (1967) refer presumably to industrial organizations, Hage and Aiken (1969, p. 309) make the point, "While these are examples of industrial firms, they suggest consequences for people processing organizations as well, since the referents of system and product goals can be applied to all kinds of organizations since the idea is one of service." A modified typology suggested by Perrow (1967) is illustrative.
Table I
Organizational System and Product Goals

<table>
<thead>
<tr>
<th>System</th>
<th>Product</th>
<th>System</th>
<th>Product</th>
</tr>
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<tbody>
<tr>
<td>Stability</td>
<td>Quality</td>
<td>High growth</td>
<td>High quality</td>
</tr>
<tr>
<td>Few risks</td>
<td>No innovations</td>
<td>High risks</td>
<td>Innovative</td>
</tr>
<tr>
<td>Moderate to Low Profit emphasis</td>
<td>Low emphasis on profit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stability</td>
<td>Quantity</td>
<td>Moderate growth</td>
<td>Reliability</td>
</tr>
<tr>
<td>Few Risks</td>
<td>No innovations</td>
<td>Some risks</td>
<td>Moderate innovations</td>
</tr>
<tr>
<td>High Profit emphasis</td>
<td></td>
<td>Moderate profit emphasis</td>
<td></td>
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</tbody>
</table>

It is believed that the above typology is applicable to a people processing organization such as a CMHC. The implications and ramifications of these observations will be discussed in terms of administrative procedures in Chapter 9.

It is recognized here that the culture and social environment are significant factors in the provision of technology and the restriction or re-direction of organizational goals. It must be emphasized that organizational goals and indeed organizational structure, when viewed in this rather truncated manner, must adjust to the technology or the organization will be subject to inordinate strain.
Implications of Technology

It is believed, as expressed by a variety of authors, such as Perrow (1967) and Hage and Aiken (1969), that the processes of work of an organization provide the basis upon which the organizational structure operates. The technology of the organization as a totality has a significant effect on salient dimensions of organizational structure. Hage and Aiken (1974, p. 299) state, "That is, technology is likely to determine whether it is formalized or non-formalized, whether it has a diverse or relatively simple division of labour, and so together the technological foundation and sub-structured social arrangement influence the sub-structure of organizational goals." With this statement in mind, the desired structure of the CMHC is examined initially in terms of the framework provided by Hage and Aiken (1969), distilling a significant dimension, that of work flow routineness. Work flow routineness is discussed as a basis for administrative strategy. This chapter also examines the conceptual implications of organizational environment and the delineation of system and product goals as outlined by Perrow (1967), also in the light of administrative strategies and implications. General propositions are suggested as a result of this discussion.

The present examination of a CMHC is concerned with the routineness of work flow of the entire organization rather than the routineness of particular treatment modalities embodied in the disciplinary biases of members of the treatment team. In other words the unit of discussion is the organization itself. The discussion relates primarily to professional staff involved in the delivery of direct treatment services within designated program areas.
An examination of statistical data provided by Mental Health Programs reflects the diversity of client characteristics perceived by program staff specifically in terms of diagnosis. These clients require the application of technologies appropriate to the specific behaviour displayed and the situation in which this particular behaviour is manifested.

The discussion of work flow routineness as a specific dimension of technology is concerned with the variety and diversity of human input into the system. The study conducted by Hage and Aiken (1969, p. 302) suggests the non-routine nature of technologies employed by a CMHC as a unit when they state, "The organizations included here are relatively homogeneous since most of them provide psychological, psychiatric or rehabilitative services of one kind or another. As one might expect in such organizations, the scores tend more toward non-routineness." In a CMHC, relative to other human service organizations, there are problems which occur that cannot be anticipated, predicted or allowed for in the movement of the system toward its organizational goals. Administrative planning in relation to both system and product goals requires some creativity and the ability to respond flexibly to a diverse range of input. In addition to the diversity and range of behaviour exhibited by clients during the initial presentation at the CMHC there is a range of inconsistency present during the period of time the patient is exposed to a particular treatment modality. The potential conflict between treatment and organizational goals may in itself tend to generate changes in the range of behaviour displayed by a client. In essence, the delivery of direct services by a CMHC may be described as being consistent with a non-routine work flow as routinized and programmed intervention on a client basis cannot be anticipated or predicted.
In light of the above discussion it is important to recognize that the processing of system input or the application of a treatment modality to a client may be standardized or require continual adjustment. Perrow (1967, p. 197) emphasizes this point and states, "Organizations uniformly seek to standardize their raw material in order to minimize exceptional situations." A movement toward certainty is exemplified. Bureaucracies in general tend to proliferate rules which are consistent with this movement toward standardization. An awareness of this phenomenon is of critical importance in addressing administrative implications. Mechanic (1973, p. 159) discusses the function of rules and states, "The function of rules is to define expected behaviour under ordinary circumstances and they serve as deterrents to behaviour that exploits the organization, its personnel or its clients or that compromises the organization's public stance." Rules are developed to ensure standards of performance.

Implications of Environment

In order to address administrative strategies appropriate to the facilitation of organizational effectiveness, it is necessary to provide a more specific discussion of the "substance" in which the CMHC is embedded. A number of assumptions are made initially in order to develop some of the issues salient to administration. Lawrence and Lorsch (1969) provide an initial base from which to articulate the importance of organizational environment. Stemming from this work it is appropriate to perceive the relationship between the organization of a CMHC and its environment as contingent in nature.
Internal characteristics of an effective and functional organization will be dependent and contingent on the characteristics of its immediate environment. As open systems CMHC's as organizations must engage in a constant exchange of resources and information with their environment in order to survive and function effectively. A CMHC depends to a large extent on input transactions perhaps as identified referred patients and output transactions seen in successfully processed patients re-introduced and more acceptable to regulatory bodies such as the Ministry of Human Resources. O'Brien (1973, p. 170) states, "Since an organization depends upon these input and output transactions for survival, the members of the environment who engage in these exchanges exert considerable influence not only over the organization's processes but even in the setting of organizational goals."

An examination of the effect of a dynamic and changeable organizational environment on the organization is considered appropriate.

A number of models are available for application to a derived CMHC, some of which are described in an earlier section. Emery and Trist (1965) present one conceptualization and suggest that within their typology a disturbed reactive environment and a defined turbulent field most closely represent the organizational climate of a CMHC.

Given, as has been described earlier, an organization's tendency to move toward certainty, organizations such as a CMHC require linkages with other organizations in order to plan effectively. A growing scarcity of resources has furthered the need to plan in concert with other human service delivery systems. A disturbed reactive environment is one in which the actions and goals of other organizations represent the primary consideration in any attempt by CMHC's to plan effectively over the long term.
Certainty is enhanced and predictability facilitated through the maintenance and retention of linkages between environment and organization. O'Brien (1973) goes a step further and states organizational environments of CMHC may be described at times as turbulent. Emery and Trist (1969) regard turbulent fields as ones in which not only the relationships among the members of the field are changing, but also the nature of the field itself is changing. In a turbulent field, predictability is at a minimum. O'Brien (1973, p. 176) states, "It seems perhaps more accurate to state that at periods of rapid technological or sociological change within the interorganizational field of mental health, the environment becomes a turbulent field for a limited period of time and then returns to a 'disturbed reactive environment' as described earlier."

Disruptions in programs and changes in existing relationships characterize such periods. Massive increases in funding to MHR during the NDP period of office would be a good example of a period of rapid change which affected the relationships MHR had established with other human service delivery systems including Mental Health. Predictability and certainty were at a premium during this period. In the CMHC administrators were giving a great deal of thought to areas of interorganizational dependence and autonomy.

A more sophisticated conceptualization of the environment of a CMHC is found in the work done by Thompson (1967). As has been mentioned in a previous discussion, Thompson (1967), Duncan (1972), Terryberry (1968), and Emery and Trist (1965) all attempt to identify several major dimensions of the task environment which may be defined as stated by Steers (1967, p. 85) as "that portion of the total setting which is relevant for organizational goal setting and goal directed activities." Suppliers of input, competitors
and regulatory bodies would be examples of organizations relevant to the concept of task environment. In a operationalization of Duncan's 4-celled typology, two important dimensions are identified on which external environments can be compared as they relate broadly to organizational dynamics which would include administrative implications. Both of these dimensions relate to the degree of certainty or uncertainty with which organizations can make decisions as to future courses of action. Steers (1977, p. 88) states, "In essence it is suggested that the 'static simple' environments contain the least amount of uncertainty for organizational planners and decision makers and the 'dynamic-complex' environments contain the greatest amount of uncertainty." The framework below is reasonably self-explanatory.

Scrutinizing the environment of a CMHC in the Province of B.C., there is an inclination to reaffirm a statement by Baker and Schulburg (1970, p. 442) when they state, "By contrast, the CMHC program employing the human services model has witnessed a major expansion of the environmental constituency to which it belongs and with which it interacts."

Consumers of community mental health programs are becoming increasingly restless, demonstrating a growing concern as to the relevance and performance of the CMHC. A government strongly reflecting the need for fiscal constraints has forced Mental Health Programs to review the allocation of staff positions, examine changing manpower requirements and respond rapidly and decisively to changing environmental conditions. Administrative reorganization in a climate of increasingly scarce resources is facilitating a change process not only in the delivery of mental health services but also in other organizations subject to the same growing awareness of the need for effectiveness and efficiency. The growing awareness of the need for primary prevention and community involvement has led the CMHC to accept input which
Table II
Characteristics of Various Environmental States

<table>
<thead>
<tr>
<th></th>
<th>Simple</th>
<th>Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CELL 1:</strong> Low perceived Uncertainty</td>
<td>1. Small number of factors and components in the environment.</td>
<td>1. Large number of factors and components in the environment</td>
</tr>
<tr>
<td></td>
<td>2. Factors and components are somewhat similar to one another</td>
<td>2. Factors and components are not similar to one another</td>
</tr>
<tr>
<td></td>
<td>3. Factors and components remain basically the same and are not changing</td>
<td>3. Factors and components remain basically the same</td>
</tr>
<tr>
<td><strong>CELL 2:</strong> Moderately Low Perceived Uncertainty</td>
<td>1. Large number of factors and components in the environment</td>
<td>1. Large number of factors and components in the environment</td>
</tr>
<tr>
<td></td>
<td>2. Factors and components are not similar to one another</td>
<td>2. Factors and components are not similar to one another</td>
</tr>
<tr>
<td></td>
<td>3. Factors and components remain basically the same</td>
<td>3. Factors and components remain basically the same</td>
</tr>
<tr>
<td><strong>CELL 3:</strong> Moderately High Perceived Uncertainty</td>
<td>1. Small number of factors and components in the environment</td>
<td>1. Large number of factors and components in the environment</td>
</tr>
<tr>
<td></td>
<td>2. Factors and components are somewhat similar to one another</td>
<td>2. Factors and components are not similar to one another</td>
</tr>
<tr>
<td></td>
<td>3. Factors and components of the environment are in continual process of change</td>
<td>3. Factors and components of the environment are in a continual process of change</td>
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Baker and Schulberg (1970, p. 442) state, "The output of such a centre has similarly affected so that it may be as relevant for the centre to help a patient receive a higher welfare check as to reduce the paranoid ideation."

Given the above discussion, it is indeed difficult to definitely "type" the organizational environment of a desired CMHC within the framework of our discussion. It is relatively easy to conform as do O'Brien (1973)
and Schulberg and Baker (1970) that in the Emery and Trist model, the environment may be presently categorized as a turbulent field. This model, however, suggests a statement at a relatively high level of abstraction.

It may be quite plausible to suggest that the organizational environment of a CMHC approaches the complex end of the simple-complex dimension. A wide variety of features must be considered both internally and externally prior to the completion of a decision. Relationships with M.H.R., Corrections and Public Health are interrelated and inter-dependent, as a high degree of co-ordination is required to facilitate organizational inputs which are fairly frequently shared. Community groups, both collectively and individually, are a significant factor in the decision making process.

As has been indicated earlier, it is relatively easy to argue that the environment of the CMHC approaches the dynamic pole of the static-dynamic dimension. A process of change at a relatively rapid pace is demonstrable by even a casual observer. If one accepts the premise that our current economic climate reflects a condition of scarce resources, we may easily identify mechanisms either established or evolving which lean toward co-ordination and joint decision making. An example of this attempt at co-ordination and a recognition of inter-dependence in the environment of a CMHC is seen in the formation of Children in Crisis committees. Programming and planning becomes dynamic as decision makers within the CMHC must take into account a wide range of diverse interests, which currently reflects an increasing awareness of the scarcity of resources. A governmental ideology is reflected in policies which are oriented toward severe fiscal constraint. Innovation becomes oriented toward making these constraints more palatable.
to field level operations. We may postulate with some safety that there is a high degree of perceived uncertainty in the organizational environment of a CMHC. Steers (1977, p. 88) states, "Not only was the dynamic-complex environment found to be associated with the largest amount of perceived environment uncertainty, but in addition it was discovered that the static-dynamic dimension was a more important contributor to perceived uncertainty than the simple-complex dimension." It is believed consistent with the above discussion to suggest that the organizational environment of a CMHC within the framework of our discussion most closely approaches Cell 4 in the preceding typology outlined by Duncan (1972).
Chapter 8

THE CMHC: INTER-ORGANIZATIONAL RELATIONS

Importance

As has been mentioned in previous discussion, the perspective adopted in viewing CMHC's seems most closely consistent with considering the CMHC as an open-system. This term explicitly suggests that the external environment influences the internal properties of the organization. It has been suggested by a significant segment of the literature that General Systems Theory emphasizes the inter-dependence and inter-linking of various sub-systems. These are two of the most important aspects of a system which increasingly forces one to consider multiple causation rather than perceiving the organization in single causal terms. In other words, it is believed necessary to examine the impact and linkages that exist between the CMHC and organizations operating within its task environment. Negandhi (1975, p. 2) states, "Thus inter-organization theorists seem to rely in part upon a broad conceptualization at the general systems level. Their overall aim, as it would seem, is to examine the impact of the external environment and/or the other social units on the internal functioning of the parent organization."
A number of theorists would appear to predominate in supplying models which permit an analysis of inter-organizational relationships and the sources of external influence on a given organization. Levine and White (1961) examine inter-organizational relationships among health agencies and suggest that community health organizations comprise a system with interdependent components. This inter-dependence is seen as being determined by: distribution and accessibility of resources, organizational functions and the degree of domain consensus existing among the various organizations. Aldrich (1971) regards this approach as being incomplete, in that it emphasizes functional inter-dependence and does not consider the variations produced as organizations work actively toward maintaining their organizational boundaries. Aldrich (1971) discusses the expansion and constriction of organizational boundaries in trying to cope with inter-organizational conflict. Baker and O'Brien (1971) and O'Brien (1973) are also critical of emphasizing the inter-dependence among organizational systems. Rather than assuming a well integrated system of community health agencies, they examine the degree and nature of interchanges between systems and suggest that organizational movement toward inter-dependence co-exists with a trend toward independence. This movement toward independence is a function of activities related to boundary maintenance. Baker and O'Brien (1971, p. 395) state succinctly, "This applying the term system to an organization implies inter-dependence in the sense of necessary input and output linkages, but also independence in the sense of maintenance of the integrity of system elements through boundary control processes." A discontinuity between the environment and the organization must exist. Indeed, Baker and O'Brien (1971) go so far as to suggest that a co-ordinated inter-dependence system of health agencies
may produce a less optimal output of services than organizations which are overtly competing and attempting to realize their own individual goals.

If we examine briefly inter-organizational relations with specific reference to a CMHC in the Province of B.C., we may demonstrate a consistency with the dominant themes outlined by Baker and O'Brien (1971). O'Brien (1973) states, "The community mental health movement and recent legislation in community mental health and comprehensive health planning has stressed the importance of comprehensiveness and continuity in care delivery as well as the involvement of local groups in the planning process." In other words, patient care in any given community depends upon the actions of a wide variety of organizations. This factor, combined with increasing specialization in service areas and the decreasing availability of both human and non-human resources, increases the frequency and intensity of contact among agencies. Collaborative relationships among human service organizations within an environment of scarce resources become necessary.

It is the intent of the subsequent discussion to address the functioning of the CMHC in relation to three impinging organizations: Riverview Hospital, Public Health Programs and Hospital Programs. Some of the more significant inter-organizational linkages between the CMHC and each of these organizations will be examined within the exchange framework of Levine and White (1960) and amplified by some of the material outlined by Baker and O'Brien (1971).

Levine and White (1961) regard an organizational exchange as any voluntary activity between two organizations which have consequences for the realization of their respective goals. Hage and Aiken (1967, p. 913) confirm the importance of this area of discussion when they state, "Most
studies of organizational inter-dependence essentially conceive of the organization as an entity that needs input and provides output linking together a number of organizations via the mechanisms of exchange or transactions."

Riverview Hospital

Riverview Hospital has been traditionally perceived as the inpatient component of the Provincial mental health delivery system. The availability of other inpatient facilities, particularly the rapid expansion of acute psychiatric wards attached to regional hospitals in the late 1960's and early 1970's, has forced Riverview Hospital to review its role in relationship to the provincial catchment area which it serves. Colls (1976, p. 11) states, "It is still to a large extent, the inpatient component of the provincial mental health delivery system, but the number of patients, the method of their admission, their condition and the treatment that they require and their disposition on release are changing variables." There is no intent at this point to outline in detail information available from government publications, statements from ministerial documents or submissions from statutory and non-statutory agencies regarding the more specific components of Riverview Hospital's organizational structure.

In 1970 Riverview Hospital was instructed to regionalize its structure and services, permitting and facilitating a more significant relationship between a designated ward of the hospital and a given segment of the provincial catchment area. It was felt that more precise program planning would be possible with this arrangement as it was anticipated that the reciprocal familiarity generated between ward and region would facilitate
more appropriate functional programming. This would occur both in terms of the requirements of the designated catchment area and the opportunity and constraints of the area of the hospital assigned to the particular region.

In 1974 Riverview Hospital made a further attempt to respond to the changing availability of services within its task environment by recommending the development of specific, defined programs with service aimed at defined populations. The hospital's "Proposal for the Reorganization of Riverview Hospital" suggests a degree of program autonomy while permitting centralized direction.

A conference held on the role of Riverview Hospital in 1976 states in its introductory position paper, "In its preparation we have leaned heavily on the large community of professional expertise at Riverview Hospital while trying to maintain an awareness of changing community needs." Among the few significant recommendations that have been operationalized has been the designation of Riverview Hospital as a secondary referral centre for areas of the province which possess an acute psychiatric ward. Riverview retains its status as a primary referral centre for areas not possessing a psychiatric ward.

These three major and significant events have led support to exchange relationships between CMHC's and Riverview Hospital.

Examining the relationship between Riverview Hospital and the services provided by CMHC's, it is necessary to recognize that the mandate of a CMHC is to provide service to all ages and patient conditions. The admitting policy of Riverview Hospital States, "The treatment facilities of Riverview Hospital are considered suitable for treating appropriately
all types of mental illness in adults under the age of 70 with the exception of the following syndromes where they exist as the primary problem: mental deficiency, sociopathy and addiction." To an extent a similar disease and population are served, but the services rendered and indeed possible are dissimilar in practice and philosophy.

It is necessary to reiterate the default model of CMHC administration which is pervasive. Non-medical Directors occupying their position by default are unable to provide medical services within the same context as the medical administration at Riverview Hospital. A Social Work-Director may well negate the value of mediation which had previously been stressed by a physician on an inpatient ward. Both practice and philosophy differ largely as a result of the default model.

To a large degree patients/clients are exchanged between the CMHC and Riverview Hospital. Patients carried by CMHC's in geographical proximity to Riverview Hospital may fall under the auspices of the Community Adult Psychiatric Service program where a Centre psychiatrist will admit and treat clients within Riverview Hospital while occupying a position shared between Centre and Hospital; as stated in (Colls, 1976). When appropriate, and in areas where the C.A.P.S. program does not function, staff members of the CMHC may involve themselves in both the direct and indirect treatment of patients admitted and under their care prior to admission. Patients upon return to their catchment area are routinely contacted by the CMHC to determine after-care requirements. Labour services are exchanged as hospital staff provide direct and indirect services both from Riverview and to an increasing degree within their community of origin.

Information on the availability of resources, such as efforts related to staff recruitment, are shared between institution and CMHC.
Information on the availability of psychiatrists is shared. Continued discussion occurring on the expansion of joint appointments and/or exchange of staff appears to be increasing in priority on the part of both Centre and Hospital.

Formal agreement underlying exchange in the above areas is noticeably lacking. Correspondence and policy statements regarding the service provided by the C.A.P.S. program are non-existent. There is little if any articulation of policy regarding co-operative relationship development with CMHC's on a provincial basis. The reason for this remains obscure.

The direction of the exchange as epitomized in the C.A.P.S. program would appear to be reciprocal, where patients are routinely exchanged between CMHC and hospital. Outpatient services provided by the CMHC attempt to meet the requirements of the post-hospitalized patient and contain the disturbed patient in the community as long as possible, until admission is inevitable. The hospital provides the opportunity for containing a patient while providing a more intensive treatment regimen than that available at the CMHC. Resources required by the CMHC related to their objectives of enhancing, maintaining or improving the social functioning of their patients are possessed by Riverview Hospital, while similar resources remain within the organization of the CMHC.

It is anticipated that the implications and nature of the exchange relationship existing between Riverview Hospital and the CMHC will directly affect administrative postures adopted by CMHC's in the face of the changing configuration of resources within its task environment.
Public Health Programs

Legislation related to Public Health services in the province dates back to 1869 when a Provincial Board of Health was established. Departmental rank was achieved in 1946. Public Health Programs is one of the two major administrative divisions of Community Health Programs. The mandate of the program is to provide treatment, prevention, environmental control services and the promotion of positive health (Annual Report, 1976). A total of 17 local health units covers the non-metropolitan areas of the province. Incidentally, these 17 health units areas are not contiguous with the 30 mental health centre catchment areas. Frequently there are several CMHC's contained within a Health Unit area. Some with suboffices. Also, in contrast to Mental Health Programs, statutory responsibility is conferred on the local Medical Health Officer and the respective Union Boards of Health. The Union Board of Health has responsibility for the administration of relevant sections of the Health Act and is composed of representatives from the municipality and the School District. Mental Health Centre representation on the board is infrequent and limited usually to specific concerns on a largely ad hoc basis.

With the division of the Health Ministry into three distinct divisions with separate leaders at the Deputy Minister level in 1959 Mental Health programs began a rapidly accelerating try toward organizational isolation. The relatively small number of staff with an extremely vague and diffuse mandate led to take-over bids particularly by Public Health programs. These bids fed by a number of reports such as that generated by facilities led to a defensive and rigid isolationist posture developed by Mental Health programs which only now is beginning to erode.
In examining and considering the nature of the exchange relationship between Mental Health Centres and Public Health Units, it would appear that the most salient and significant sub-system of Public Health is the service provided by Community Public Health Nursing and the Home Care Program. The most visible and most significant, perhaps, discipline is that of Public Health Nursing, and the Public Health Nurse is the staff member who deals most directly with the majority of residents in her status as a primary health care worker (Annual Report, 1976). Her mandate is broad and at a high level of abstraction, encompassing a concern with people of all ages, social and economic levels, and with all types of health needs in all communities within the province. The 1976 Annual Report states of her function, "Emphasis is on health promotion, early identification of potential health hazards and problems, referral for treatment and then follow-up, rehabilitation and promotion of individual and family responsibility for care. Services are family-centred, with each individual being considered in the context of his family and community life and relationships." Participation in the whole range of health agency services and the promotion of programs designed to promote a more positive life style are explicit. Four major programs are delivered: maternal and child health services in conjunction with physicians and concerned individuals, infant and preschool services with an emphasis on health appraisal and protection; identification of health hazards within the school system, and the promotion of health and services related to family, adult and geriatric populations. The fourth service involving family and adult services is in all likelihood the service which most closely relates to the service delivery provided by the CMHC. In 1976 12,000 visits by Public Health Nurses related to
mental illness. Two areas of service are significantly identified in the Annual Report (1976) which states, "Mental Health was emphasized and promoted in all contacts with individuals and families and as part of every program offered. Follow-up of attempted suicides, group work with 'Parents in Crisis', work with individuals under emotional or mental stresses, etc. was carried out by Public Health Nurses."

Home Care services are a relatively new service provided by Public Health Programs and basically involve the care and treatment of individuals in their homes who would otherwise be institutionalized. An assessment of each patient is done by the Home Care Co-ordinator in conjunction with the physician concerned. Services are provided by Public Health nurses, home care nurses, physiotherapists and when necessary services are purchased from other organizations. A "hospital replacement" objective is identified and available to 80% of the population. No cost is levied on the patient during the period he would otherwise be hospitalized. There is no direct reference to the provision of exclusively mental health related services to be found in policy statements produced by Public Health Programs. It is widespread knowledge, however, that the Home Care Program does not provide service to individuals whose primary problem relates to an emotional or behavioural concern. Services are not provided to individuals suffering organic brain damage as a primary problem.

The Community Human Resources and Health Centre program is worthy of a brief discussion. Although limited to four areas of the province (James Bay, Houston, Granisle and the Queen Charlotte Islands), it is a manifest example of a link or exchange relationship between the Ministry of Health and the Ministry of Human Resources. The objective of the program
is to provide for community involvement, integration of services, and a health promotion and prevention focus. The delivery of this service is provided by staff members seconded from their respective departments with the exception of James Bay and Granisle. A common administration for staff in each centre is designed to facilitate the movement of the inter-disciplinary team to identified program objectives. An evaluation of the activities of these Centres may have wide-reaching implications for the delivery of a wide range of health care services in the province. In Quebec the CMHC activities have been subsumed into the CLSC and have lost their power.

A more specific examination of the dimensions of the relationships between Public Health and CMHC's is in order. The majority of the subsequent material is taken from Public Health Policy Manual Vol. III, Ch. 11 (1972), (see Appendix III). This source is regarded as the most current by senior Public Health staff. It is necessary to keep in mind that a CMHC is a regionally based mental health resource offering patient service, consultation, education and participation in appropriate community programs. It is generally accepted that client populations are exchanged on a relatively routine basis by both organizations with the notable exception of Home Care Services where a unilateral exchange occurs as nursing staff may refer to a CMHC. Exchange of direct patient treatment services is regarded generally as reciprocal. Joint exchange of direct service occurs as stated in the Policy Manual (1972, p. 8): "In some cases Public Health nurses are asked to visit the home of each child who is seen at the CMHC even when the initial referral has come from a private physician or the school. The purpose of the visit is first, to explain the procedure which will occur at the CMHC, to allow the family to ask questions and to guide and encourage
them in preparing the child." In most cases, however, this is not a routine procedure. Generally, and again there is no policy guideline to refer to, CMHC staff accept both self-referrals and direct referrals from Public Health nurses. Physicians may be informed by either the PHN or by the CMHC at the time of activation or they may not be notified depending on local practice. Reciprocal exchange of written material varies as stated in (Appendix III) (1972, p. 8), "The form in which written information is prepared by the Public Health Nurse is a matter of local agreement between the CMHC and the Health Unit concerned." The exchange of other written material such as records and correspondence is more explicit and codified. Mental Health Centre files remain the property of the CMHC rather than the Health Unit. Public Health nurses frequently compile their own Mental Health files. The Policy Manual is explicit in stating that there should be a clear distinction between Mental Health Centre files and those maintained by the Health Unit.

Public Health Nurses are advised as a matter of policy (Appendix III) that many factors influence co-operative activities between a CMHC and health unit, staff, among them:

"-- the types of programs offered by each agency
-- the interests, capabilities and limitations of individual public health staff in mental health services
-- the willingness of mental health personnel to become involved in health unit programs which emphasize mental health
-- the availability of other professionals in the community who participate in mental health programs."

The last item explicitly recognizes that the degree of exchange is predicated on the availability of resources which incidentally are
becoming increasingly scarce. The frequency and intensity of the exchange would be significantly related to the availability of necessary elements from outside the local health care system.

In summary, Mental Health service delivery is perceived as an integral part of total health delivery. Explicit recognition is made of the responsibility possessed by Public Health in the promotion of mental health. Organizationally there is a movement on the part of both Public Health and Mental Health to delineate their organizational domains (see Appendix III). It may be safely assumed that a minimal degree of domain consensus has been achieved by both organizations as the intensity and frequency of the exchange relationship, particularly in the area of consumer and labour services, is relatively high. Levine and White (1961, p. 377) state, "These processes of achieving domain consensus constitute much of the interaction between organizations. While they may not involve the immediate flow of elements they are often necessary pre-conditions for the exchange of elements, because without at least minimal domain consensus there can be no exchange among organizations."

The exchange of non-labour services such as equipment remains generally low in terms of pervasiveness within both organizations, although where it does occur the exchange is of a high degree of frequency. The exchange of material, supplies and shared utilization of equipment, such as copying machines, remains very limited with little codification of requirements and regulations. Informal exchange does, of course, occur, but this is usually minor.

Joint exchange relationships are scarce and are usually predicated on a high degree of policy co-ordination and agreement. An example may be
seen in the increasing degree of psychological consultation services provided the Public Health four year old screening program. Elements are not transferred, but both organizations direct their activity at the consumer or client. No explicit policy exists in this area at present.

Hospital Programs

In 1943 the Federal Government made a study of social services in Canada, the Marsh Report. The Heagarty Committee on Health Insurance was formed.

As a result of this Federal interest the Federal Provincial Conferences of 1945/46 discussed and agreed the development of Health Insurance at the same time that the Constitution was under review. The Constitution had to be revised to allow the Federal Government to become involved in Health financing.

In 1949 the Federal Government began to take a hand initiating hospital construction grants. The training of psychiatric staff also began in this year, along with demonstration grants in both Mental Health and Public Health. The Hospital Construction Grant Program proved to be very popular. As a result of this Proinvical government quickly ran out of money particularly in the area of hospital operating costs. The Provinces were forced to approach the Federal Government in 1957 and ask for cost sharing of these costs.

It began to be financially advantageous for physicians to admit their patients to hospital care. A hospital denominated system of health care became firmly entrenched.
By 1969 a Task Force Report on the Costs of Health Care was generated which suggested alternatives to hospital care such as Community Health Centres. This move was of course strongly united by the existing hospitals and by the medical profession which saw it as a threat to their income. The medical community became more militant and strengthened its position asserting the need for hospital care. The threat however continues in that in 1977 a block funding arrangement was established with the provinces which potentially permits greater flexibility in the dealing of health care.

The medical profession continues to regard psychiatrists who have moved into the service structure of the CMHC as traitorous in their actions. Currently however a 12 month project responsible to the Minister of Health is examining means of relating services originally hospital oriented to emphasize a more community related approach. The co-operation of physicians in both this study and a recent Mental Health Survey conducted by John Cumming is characterized by a note of passive aggression.

With the potential for increased flexibility and flexibility and responsiveness provided by block funding, a number of informal exchange relationships have gained in importance between the Psychiatric Wards of Regional Hospitals and the Mental Health Centres contained within their catchment area. The tentative nature and diversity of relationships between MHC and hospital is characterized by a virtually complete lack of codified policy and for that matter even written correspondence with significant and province-wide policy implications. Therefore, the following material is largely anecdotal and must be discussed in that light.

As we have noted in previous discussion, all organizational relationships are related and predicated upon the control and flow of cases,
labour services and other resources. With the increased community accountability of hospitals with their attendant boards, highly unique and individualized relationships with MHC's have developed, perhaps of necessity. There has been little centralized co-ordination of the nature of the exchange relationship. Voluntary agreements and implicit understandings are manifest. With the increased development of Psychiatric Day Care Programs over the last five years, the degree of domain consensus with the CMHC has markedly decreased. Disease covered, the population served and the services rendered are markedly similar in both organizations. A number of attempts, usually highly individualized, have been made by both organizations to achieve a greater degree of domain consensus. Experiments involving the sharing of labour services and physical services are generally less common as hospital-based Day Care Programs increasingly expand into the community and encroach upon what has been perceived until fairly recently as the domain of the CMHC.

A fair example of an unsuccessful attempt to restrict the domain of the psychiatrists on psychiatric wards and thus facilitate a more orderly allocation of resources is seen in an attempt to codify admission criteria for in-patient psychiatric units (see Appendix IX). The criteria mentioned in this correspondence are at a high level of abstraction. The interpretation of the criteria is left at the discretion of hospital staff which in turn is influenced by funding expediency and the nature and tone of the medical community. A psychiatrist in a given community may have a caseload and interest in the area of alcoholism with an income dependent on this type of patient. Frequently this physician will be permitted to hospitalize
this type of patient with a "cover" diagnosis of depression and they regularly ignore admission criteria stipulating alcoholics may not be admitted. Communities possessing only a small number of physicians may find their physicians have almost total control of the treatment processes and criteria covered for admission and discharge.

The exchange of cases or the consumer of service, however, occurs frequently between CMHC and hospital. If one considers inpatient services, the need for and exchange with the CMHC is readily apparent. The inpatient unit is generally a deliniated function as seen in prohibitive rules strictly regulating the contact of ward staff with community agencies and services. Labour services are generally not shared with the inpatient unit, but, increasingly, an intent to share is being expressed by the CMHC, who see a distinct advantage in having a psychiatrist provide service jointly at the CMHC and as the Area Clinician of the inpatient unit. Traditionally the direction of the exchange between hospital and CMHC. The development of outpatient programs has tended in many communities to breed competition for available patients. Again the degree of domain consensus has decreased with the heightened activity of hospital-based Day Care Programs. Psychiatric Day Care and Outpatient Programs would tend to have a unilateral exchange relationship with the CMHC. Admittedly this exchange occurs infrequently, but on occasion a specialized resource may exist in a particular program.

It would appear that as the degree of differentiation of mental health services increases there is an increasing recognition that integration is required. The problem is of course compounded by the default model of CMHC administration which greatly inhibits the secure negotiations of
co-ordinated arrangements largely on the part of the non-medical Director.
The process of mutual adjustment is largely predicated on the adequate security of the parties negotiating the agreement. Currently an informal agreement exists that a CMHC must be involved in the planning process for a psychiatric hospital-based day care program. An informal agreement has been reached with Hospital Programs, that, if a resource exists in the community which has the potential to provide a service similar to that of a day care program, this resource may be funded and developed rather than develop a wholly new hospital-based service. It has been agreed that a MHC will be notified and involved in any day care program submitted to the Rate Board for approval. A thorough examination by Personnel of Hospital Programs will then occur as to the availability of resources already existing within the catchment area of the hospital. It is known largely from anecdotal sources that a preponderance of existing resources with this potential have been developed by the CMHC with the objective of providing structured activity programs for those populations served by both CMHC and hospital.

It is believed that the environment of the CMHC which includes the organizations discussed is characterized by resources scarcity. It is now widely accepted that resources scarcity is significant in the development of dependencies and the limitations of organizations function. Inter-dependencies are particularly obvious in the area of information flow. The development of individualized information systems within different departments of the Health Ministry is particularly disturbing. Indeed the planning function subsumed by administration in community mental health is dependent on accurate, reliable and routinized information regarding the activity of organizations within the environment of the CMHC. Feldman
(1973) states, "One of the major tasks for the administration of a mental health service is to be aware of the variety of interchanges going on between his organization and its organization set."

A statement by Levine and White (1961, p. 37) illustrates dependencies which develop among health organizations. "Usually agencies are unable to obtain all the elements they need from the community or through their individual efforts and accordingly have to turn to other agencies to obtain additional elements. The need for a sufficient number of clients is often met more effectively through exchanges than through independent case finding procedures."

It may well be true that the ability of administrators to work with members of other organizations is a determinant of the success of inter-organizational collaboration irregardless of the structure of the CMHC.
Chapter 9

ADMINISTRATIVE PROPOSITIONS

It is the intent of this chapter to summarize a number of propositions related to the exercising of administration within a CMHC. It is suggested that these propositions will reflect a cognizance of technology, environment and organizational goals. The uniqueness of the dimensions discussed in these three areas will suggest organizational postures unique to a CMHC.

It must be emphasized that the current non-medical administration has taken over responsibility for technology, environment and goals largely as a result of default on the part of the psychiatric specialty and the reluctance on their part to assume accountability in this area.

Administrative Propositions - Technology and Goals

Primary Proposition A

A CMHC contained within the parameters of our discussion is characterized by a non-routine work flow.

Secondary Propositions

1. A CMHC characterized by a non-routine work flow is likely to have less need for the formalization of organizational policy, procedures and rules.
2. A CMHC characterized by a non-routine work flow is less likely to require rigid codification of organizational roles.

3. A CMHC characterized by a non-routine work flow is likely to employ individuals with a high degree of professional training.

4. A CMHC characterized by a non-routine work flow has more need for decentralized decisions.

5. A CMHC characterized by a non-routine work flow is more likely to require co-ordination through feedback.

6. A CMHC characterized by a non-routine work flow requires the exercise of a high degree of discretion on the part of those who supervise.

As has been mentioned in previous discussion the relationship between organizational goals and the degree of routineness of work flow is intimate. The following propositions related to CMHC administrators must be viewed in the light of a statement by Perrow (1969, p. 202) when he states, "But the comments are meant to suggest how goals may be shaped or constrained, though hardly specific through the influence of technology and structure." Bearing in mind previous discussion related to the distinction between system and product goals, it is possible to generate further propositions which have in substance been experimentally verified by both Perrow (1967) and Hage and Aiken (1969).

7. A CMHC characterized by a non-routine work flow is more likely to emphasize morale as a system goal rather than efficiency.

8. A CMHC characterized by a non-routine work flow is more likely to emphasize quality than quantity as a product goal.

9. A CMHC characterized by a non-routine work flow is more likely to emphasize innovation.

10. A CMHC characterized by a non-routine work flow should demonstrate an increasing degree of internal differentiation.
Administrative Propositions - Environment

Primary Proposition B

The task environment of a CMHC is characterized by a primary disturbed reactive environment and at times of rapid socio-technical change, such as exist currently, there are turbulent field conditions present.

As has been discussed there has been an increasing emphasis on the development of decentralized mental health serviced. The actions and goals of organizations such as acute psychiatric wards and Public Health services represent a primary consideration in planning processes carried on by CMHCs. The movement of the CMHC toward the reduction of uncertainty and the decrease in environmental predictability has given rise to inter-organizational linkages such as inter-agency committees developed within the catchment area of the CMHC. A disturbed reactive field is present in the absence of profound socio-technical change.

The past several years have seen a proliferation of studies relating to the Mental Health field. The Foulkes Study laid the basis for increased political uncertainty. At present three studies are in process which have effectively blocked planning procedures on a provincial, regional and local basis. The seconding of Long-Term Care positions to Mental Health Programs has effectively altered relationships with Public Health. New liaisons are developing rapidly with much uncertainty generated as to the eventual nature of more stabilized conditions. Turbulent field conditions appear pervasive.
Secondary Propositions

11. A CMHC with an environment characterized by turbulent field conditions has an increasing need for environmental monitoring procedures.

12. A CMHC characterized by turbulent field conditions has an increasing need to assess the value of multiple exchange relationships.

13. A CMHC characterized by turbulent field conditions has an increasing need to develop voluntary exchange relationships with a movement toward contractual exchanges.

14. A CMHC characterized by turbulent field conditions has an increasing need to facilitate communication among boundary-spanning personnel.

15. A CMHC characterized by turbulent field conditions has an increasing need to examine the value of existing exchanges with other organizations occupying the task environment.

16. A CMHC characterized by turbulent field conditions has an increasing need to develop internal integrative mechanisms.

17. A CMHC characterized by turbulent field conditions has an increasing need to differentiate into sub-units.

These propositions may be regarded as hypothetical and subject to experimental verification. However they do represent, it is believed, a pragmatic and potentially operational interpretation of current literature and events.
Chapter 10

SUMMARY APPLICATION OF PROPOSITIONS TO STEERS MODEL

It is the intent of this chapter to apply the propositions generated in the previous work to a model of management proposed by Steers (1977). The discussion is concerned primarily with the facilitation of organization effectiveness through the application of managerial strategies consistent with the propositions related to identified dimensions of technology, environment and goals. What can the Director of a CMHC do in order to enhance his effectiveness?

Steers addresses six areas of administrative concern. Five of these areas will be discussed as relevant to the process of a CMHC. These areas are:

1. Strategic goal setting
2. Resource acquisition and utilization
3. Communication processes
4. Leadership and decision making
5. Organizational adaptation and innovation

It is suggested by Steers (1977) that if these areas are addressed and acted upon by an administrator, there is a movement toward organizational
effectiveness. These factors largely determine the extent to which an organization's resources are efficiently applied toward long term organizational interest.

It is necessary to discuss briefly the rationale for adapting these propositions to the model proposed by Steers (1977). A pervasive theme, which one may extract from studies which view organizations as open systems, suggests that some configurations of organization and management behaviour are more consistent and appropriate to certain task and environmental characteristics. We are concerned here with the "fit" between organizational technology and goals, and the environment in which the organization is embedded. Harvey (1967, p. 258) states, "The question is not one of rational decision-making versus non-rational decision-making, but rather a question of identifying the kinds of technical and organizational conditions which serve to enhance rationality in some circumstances and impede its operation in others." It is suggested that the propositions outlined in the previous discussion are consistent with facilitating the effectiveness of an organization such as a CMHC, given the structure and process outlined in the desired model and in subsequent discussion.

A final statement by Gabarro (1973, p. 197) sums up the writer's position: "The obvious implication of work by Lawrence and Lorsch and others is that there is no single 'best' prescription of organization appropriate to all situations, but rather that appropriate patterns of organization vary depending on task and environmental demands. A second implication, which is particularly salient to the problem of change, is that if an environment changes in significant ways the organizational patterns needed within a system also change."
It is necessary to be cognizant of the consideration that organizational effectiveness is not a terminal state or identifiable as an end point. It is a relative condition as stated by Steers (1977, p. 136) when he states, "Hence we speak of an organization being relatively effective or ineffective, instead of being entirely one or the other. The job for management then is to utilize the tools under its control to improve the relative degree of goal attainment and effectiveness over time."

**Strategic Goal Setting**

Goal setting within the structure of a CMHC may be characterized by such adjectives as ambiguous, unclear, vague and paradoxical. The gap between operative and official goals is great. Due to the current autonomy of the majority of CMHC's there is a tendency on the part of the CMHC to prioritize operational goals and only apply those official goals which are consistent with the perceived requirements at the local level. Until a middle management structure as reflected in the Acting Regional Program Director position is legitimized the priority of operational goals will continue. This is easily justified by the "service ethic" and the consequent "need" of the patient.

The process of organizational goal setting as discussed by Steers (1977) involves initially the determination of operational goals and secondly the specification of operational objectives in terms which are subject to a degree of measurement on a continuum leading ultimately to organizational goal attainment. Concentrating specifically on organizational goals, the planning process is seen as an essential feature or function of the manager of a CMHC. The planning which occurs on the part of the manager
is designed to further organizational goal attainment, as suggested by Steers (1977, p. 138) when he states, "In essence, it is suggested in this exhibit that if sufficient attention, planning and co-ordination are employed in the successive identification of goals as one moves down the hierarchy from departments to groups to individuals, then subsequent employee efforts should be largely directed toward organizational goal attainment." Unfortunately Steers (1971) does not emphasize operationally the official goal dichotomy currently present within Mental Health Programs.

It is necessary to review Steers' statement in the light of Primary Proposition A, Secondary Proposition 1, and Primary Proposition B, which emphasize non-routine work flow and environmental turbulence. The structure of the organization is predicated largely on the work process which is undertaken and the environment in which the organization is embedded. Given a non-routine work flow, co-ordination of staff within a planning process toward organizational goals is more likely to occur in a configuration of mutual adjustment between manager and staff members. Hage and Aiken (1969, p. 305) state, "If technology can be routinized, then coordination can be and probably will be planned and programmed. If it cannot, then coordination must be effected via feedback." Co-ordination through the application of planning is negated within a CMHC as the programmed interaction of tasks is not as possible when one considers the implications of Secondary Propositions 4 and 5, emphasizing decentralization of decisions and co-ordination through feedback.

Decision-making within a CMHC with reference to organizational goal setting must take into account those organizational members which interact most frequently with the clients. Both Perrow (1967) and Hage and Aiken (1967) confirm a power structure which is decentralized in an
organization which is characterized by non-routine work. Co-ordination by feedback is a necessity, as articulated by Perrow (1967, p. 199) when he states, "Coordination by feedback, on the other hand, refers to negotiated alterations in the nature or sequence of tasks performed by two different units."

An appropriate tactic for strategic organizational goal setting requires the facilitation of mutual adjustment by manager and staff members. The process of mutual adjustment in strategic goal setting is further reinforced and suggested by Secondary Proposition B, which affirms the existence of turbulent field conditions in the environment of a CMHC. The greater need for internal differentiation under Secondary Proposition B conditions requires a higher degree of communication between boundary spanning personnel and the manager of the CMHC. The higher degree of environmental uncertainty reflected in turbulent field conditions requires the manager to broaden his base of task-relevant information. Procedures for developing systemic monitoring units and furthering internal integration among staff are required in order to facilitate strategic goal setting.

Resource Acquisition and Utilization

Steers (1977, p. 138-141) suggests that an organizational manager must direct effort toward the securing of necessary resources and the utilization of these resources in as efficient a manner as possible. He identifies three dimensions of activity: system integration, management policies and organizational control systems.

If one remains cognizant of Secondary Propositions 16 and 17 and Primary Proposition A, stressing an increasing need for integrative
mechanisms under turbulent field conditions combined with a need to differentiate into sub-units, one can suggest that in a CMHC there is an increasing need for the manager to facilitate internal integration.

The implementation of standardized policies and practices is a basic requirement of managers. Steers (1977, p. 139) qualifies and states, "Although such policies have often been justly criticized for being too rigid, arbitrary and unresponsive to individual needs, there still remains a legitimate place for policy concerns in the pursuit of effectiveness."

Policy operation in a CMHC may either impede or facilitate organizational effectiveness. This area as applied to a CMHC must be considered in the light of a non-routine work flow. Given a non-routine work flow and co-ordination through mutual adjustment based on high internal and external uncertainty, it is suggested that the degree of specificity of policy, procedures and rules must be relatively low in an organization such as a CMHC. Mechanic (1973, p. 160) suggests implicitly flexible organizational response to internal and external uncertainty is reinforced by the existence of professional associations which protect rule violators from external criticism.

Steers (1977) suggests that organizational control systems are directed at maintaining consistency between the human resources of the organization, and their required tasks. The development of these resources and their utilization must fit with the needs and goals of the organization. Mutual adjustment as a method of co-ordination has been discussed previously. Secondary Propositions 1 and 2, specifying less of a need for the formalization of organizational policy and a lesser need for the codification of organizational roles, and to an extent a tendency toward more professional training of staff, are believed relevant to the subject of organizational
control within a CMHC. Organizational control is established in any organization, largely through the use of a rules manual and varying degrees of job specification embodied in a job description. A non-routine work flow and less formalized policy suggest that in a CMHC the degree of specification of work procedure and rule codification is relatively low. Indeed, with a non-routine work flow, this is a necessary condition of work flow that is variable, non-routine and a technology of which little is known in terms of efficacy.

It is incumbent on a manager of a CMHC to recognize the ineffectiveness of codifying role behaviour as a method of organizational control. The manager must be cognizant of Secondary Proposition 3, which suggests a high degree of professionalization among employees of organizations such as a CMHC. It is suggested that identification with a professional organization facilitates an individual to internalize principles and ethics which govern his behaviour while on the job. In referring to organizations possessed of a non-routine work flow, Hage and Aiken (1967, p. 308) state, "In contrast, using psychiatric skills requires at a minimum a master's degree, and more advanced training is often desirable." Interestingly, this situation has its drawbacks as discussed by Blau and Scott (1967), and as mentioned earlier.

An approach to the integration of financial resources and human resources may be seen in the recent implementation of a Needs Assessment approach to the delivery of mental health care. This rather sophisticated approach attempts to relate community need with required staff resources and assigning a dollar value to staff time required to meet expressed community need.
Communication Processes

In discussing communication processes within the context of organizational effectiveness, it is necessary to reexamine the role of co-ordination as a base for other areas of management functioning such as leadership and decision-making. Communication processes in a CMHC are of crucial significance as stated by Steers (1977, p. 148): It is generally believed that effective communications are particularly important in organizations: (1) that must deal with a high level of uncertainty, (2) that are highly complex and (3) that employ technologies that do not easily lend themselves to routineness or automation. All three of these factors are highly significant in the structure of the CMHC that is being discussed.

It may be regarded as a truism that an awareness of the importance of communication processes is a basic foundation for the achievement of organizational effectiveness, indeed even the survival of the organization itself. The general balance in movement of an organization and feedback mechanisms related to task relevant information requires the introduction of constraints which will reduce diffuse and random information, and emphasize the development and utilization of informational channels directly related to organizational objectives.

Whittington (1973, p. 81), in discussing communication within the context of a CMHC, states, "It is also important that the leader has direct access to open communication between himself and a broad cross section of the staff or the entire staff of the agency if this is feasible." This statement is of paramount importance when one considers a number of the secondary propositions stated in an earlier part of this chapter. Secondary Proposition (4), in recognizing a non-routine work flow, suggests the need
for decentralized decisions involving the work process at hand. Decisions generally speaking are displaced downward in the organizational hierarchy as decentralization is encouraged. Whittington (1973, p. 64) states, "They generally displace decision-making downward through the organizational hierarchy, encouraging staff at all levels to make independent decisions whenever possible without recourse to higher authority."

The high number of employees with professional training who address their work in relative isolation are required to make decisions on an immediate basis without prior consultation with the Director of the CMHC. The CMHC Director must recognize this need for a decentralized decision-making structure and also accept that within an organization with a non-routine work flow there must be consideration given to Secondary Proposition (5) which suggests that the manager to more likely require co-ordination through feedback loops or as Perrow (1967) would say, the process of "mutual adjustment." The variability of the work flow quite obviously requires readjustment and realignment of both procedures and policies between manager and line staff of the CMHC. Routinized dialogue through regular staff meetings, case conferences and such devices as "communication" books must be considered of prime importance.

Steers (1977, p. 150) discusses communication and, along with delinearing three areas of communication concern, states, "If communication is considered an essential aspect of improving organizational effectiveness, then questions are logically raised concerning ways to improve the exchange of needed information in organizational settings. Specifically, the problem for management here is to improve the accuracy, flow and acceptance of relevant communication so that uncertainty is reduced to its lowest level."
Communication processes may initially be examined in terms of the direction of the flow. Downward communication flow may be facilitated within a CMHC by the increase of redundancy provided by utilization of multiple communication channels. Both verbal and written messages may be utilized simultaneously with the degree of intensity regulated by the number and/or direction of carbon copies.

Downward communication from management to staff may be through the utilization of performance appraisals. This, of course, is consistent with the utilization of feedback loops as a primary method of co-ordination. Related to performance appraisal is a recent decision to raise the level of acceptance of the traditional performance evaluation by adding a format provided by an innovative staff member who has a very prestigious clinical reputation. It is anticipated that a general and required protocol supplemented by a more specific and accurate process will enhance the acceptability of annual performance evaluations required of all staff.

In considering communication directed upward, the problem of overload and distortion is relatively limited within CMHCs, primarily by virtue of their small size. Approaches such as queuing are not required.

Horizontal communication is perhaps the most significant direction occurring within CMHCs. The multidisciplinary nature of the work force and the relative scarcity of accessible external expertise requires distortion-free communication among team members. Case conferences are a primary method for achieving this type of horizontal communication. Problem situations, however, occur on a relatively unpredictable basis and formal case conferences are usually not possible in time to satisfy an acute need. The degree of uncertainty is high within the work flow.
Frequently several CMHCs may organize themselves in such a way as to facilitate an efficient use of in-service education. A workshop may involve a cluster of CMHCs, permitting exposure to new expertise and the opportunity to learn of innovative programming both through the content of the workshop and informal communication with staff members attached to other CMHCs.

If one considers Primary Proposition B, which suggests environmental instability, there are a number of implications for a Director attempting to further organizational effectiveness. Secondary Proposition (11) suggests the necessity for environmental monitoring techniques predicated on the existence of turbulent field conditions. Those staff members assigned or accepting boundary spanning roles must route information either to the Director or to a decision-making group responsible for accessing that particular task relevant information. It is the Director's responsibility to facilitate this process.

Secondary proposition (14) emphasizes the facilitation of information among boundary spanning personnel. It is important that a consistent strategy be shared among these staff. A shared approach in dealing with intake procedures and referral criteria is essential in contacts with external agencies.

The Director has the responsibility to be cognizant and act on these factors. He may attempt a variety of techniques to develop interpersonal skills among staff members of the CMHC. Reward systems may be utilized which would further staff co-operation and facilitate the accuracy, flow and acceptability of communication.
Leadership

Steers (1977), when discussing leadership, quotes an operational definition of the term provided by Katz and Kahn (1966, p. 302) and states, "We consider the essence of organizational leadership to be the influential increment over and above mechanical compliance with routine directives." In other words, leadership must be more than the enforcement of mechanical and routinized procedures.

In a CMHC, as indicated in Primary Proposition A, the existence of routinized procedures is very limited. Katz and Kahn (1966) identify three major functions of leadership which may well be applicable to the current stage of evolution of the CMHC in our Province. Reference is made to the incompleteness of organizational design. It is well known that written policies and role functions of employees may not coincide with the operational needs of the CMHC. It is important for the new employee to learn "how things are really done." The function of the leader in this particular instance is to operationalize the policies and job descriptions within the organizational realities of the CMHC. Frequently the Director may be forced to request a rewriting of the Job Description prior to the hiring of new employees.

The diverse and unique needs of each CMHC must be taken into account by the Director, along with the "fit" between the prospective employee, his expertise and the expertise available to the CMHC both external and internal to the organization. Secondary Proposition (2), emphasizing less rigidity in organizational roles, is applicable, along with Secondary Proposition (6) which suggests the need for a Director of a CMHC to exercise a relatively high degree of discretion. The degree of discretion applies
primarily to service delivery within the constraints of existing funding, but also may be seen secondarily in areas such as personnel management.

Both Steers (1977) and Katz and Kahn (1966) draw attention to changing environmental conditions as reflecting a need for leadership in the movement toward organizational effectiveness. Consistent with Primary proposition B, both authors address the futility of relying on built-in stabilizing devices to cope with high magnitude socio-technical environmental changes. Existing adaptive mechanisms may fail, requiring coping devices available only through leadership. Katz and Kahn (1966, p. 306) state, "It is adaptation of such a scale which demands invention and creativity beyond the performance of role requirements, it requires leadership of a high order."

Steers (1977) refers to the function of leadership as encompassing both instrumental and socio-emotional activities within the organization. Miner (1976) referred to similar activities when he discussed task and maintenance goals. A differentiation is made between activities of the leader related to goal-relevant activities and the function of the leader in enhancing the personal satisfaction of staff within an organization. Secondary Proposition (7) emphasizes that a Director of a CMHC is more likely to stress morale as a system goal rather than efficiency. This proposition and emphasis may be understandable when one recognizes the relative scarcity of skilled manpower in the psychiatric field and the expectation that those hired will act according to internalized professional ethics. The Director will rarely, if ever, question the effectiveness of a fully qualified professional within a CMHC. Effectiveness is usually assumed.
Decision-Making

A firm linkage may be established between the activities of the leader of an organization and the process of decision-making peculiar to the respective organization. A linkage must also be acknowledged with the act of policy-making.

Steers (1977) addresses decision-making as a process of selecting among available alternatives. The quality of the decision is regarded as being predicated on the recognition and search for possible causes to the problem, the formulation of alternatives in terms of positive or negative outcomes and finally the rationality and appropriateness of the goals identified by the decision-makers.

Katz and Kahn (1967, p. 259) make reference to the relationship between policy-making and decision-making when they state, "Policy making is therefore an aspect of organizational change — the decisive aspect. Policy-making is also the decisive aspect of that level of leadership which involves the lateration, origination or elimination of organizational structure." Unfortunately, Katz and Kahn (1967) neglect to address the implications in terms of organizational process which may also be changed reflecting a change in the organizational structure.

Perhaps the most relevant and salient issue to discuss in terms of the operationalization of this material relates to the degree of participation in decision-making. Or, in other words, the degree to which staff members of a CMHC participate in the process of making a decision which directly affects the way in which they do their work. If one considers pragmatically the inter-disciplinary mix of professions, the relatively small number of staff and the historic emphasis on CMHC program autonomy
within a given catchment area, one is inclined to suggest consistency with the general opinion that an authoritative administrative style does not optimally serve the super-ordinate goals of the CMHC. The difficulty occurs when one attempts to take into account perceptual differences occurring among diverse professionals relating to a heterogenous staff in areas of great demographic diversity.

In order to provide for some degree of consensus between organizational goals and the treatment goals of the professional within the organization, it is necessary to generalize and emphasize a statement by Whittington (1973, p. 75) when he states, "The basic goal is to optimize ego-involvement on the part of the staff by ensuring their participation in decision-making that affects their personal and professional futures and the futures of their clients or prospective clients." The responsibility for the decision and the ultimate authority must remain with the Director, however, with provision and recognition of feedback loops through the process of mutual adjustment referred to earlier. A very tricky process!

The expansion of the roles of staff in a CMHC to include selected areas of responsibility for the presentation of factors relating to the problem identification and formulation of alternative stages of decision-making would seem to be an appropriate form of goal synergistic behaviour. The decision, in essence, would rest ultimately with the Director, but the recognition of the need to decentralize aspects of the decision-making process is of significance. Secondary Proposition (4) which refers to the need for decentralized decisions would seem consistent with this discussion.

The role expansion of staff members to include this function on a delegated basis would seem consistent with Secondary Proposition (7), which
emphasizes that an organization with a non-routine work flow is more likely to emphasize morale as a system goal rather than efficiency. The participatory involvement of staff in decision-making would suggest a recognition on their part that they have a significant degree of control over not only the application of their respective technology, but also the general service orientation, direction and processes which occur both internal and external to the CMHC.

The discussion to this point has dealt primarily with generalizable statements addressing both program and treatment modalities employed within programs. However, Secondary Proposition (3) refers to the correlation between a non-routine work flow and a high degree of professional training. Decisions related to the application of specific technologies to clients by specific disciplines is usually completely decentralized with the assumption that this delegation is consistent with the professional nature of the staff. However, case conferences and intake procedures are methods utilized by the organization to raise the level of the decision-making process. Involvement in case conferences is usually voluntary, while intake meetings are not and may be utilized as a monitoring device for individual professional effectiveness.

In summary, it is necessary for the Director to effect a compromise as indicated by Whittington (1973, p. 81) when he states, "The leader is constantly caught between opposing goals. As mentioned, he must reconcile the comfort goals of the staff with the production goals of the community. He must reconcile the antithetical goals of order vs. freedom, of stability vs. flexibility, of predictability vs. creativity."
Organizational Adaptation and Innovation

Throughout the course of the previous discussion there has been reference to the primary base of a CMHC as an open system which in the course of its existence develops boundary-spanning transactions with the environment in which it is embedded. Authors such as Emery and Trist (1965), Terryberry (1968), Duncan (1973), Lawrence and Lorsch (1967), Gabarro (1973) and Thompson (1967) all discuss the importance of addressing the relationship between organization and environment and the significance of boundary-spanning activities. Terryberry (1968) particularly suggests that organizational change is increasingly externally induced and that organizational adaptability is a function of the ability to learn and to perform according to changes in the environment. Most of this material has been touched upon in previous discussion.

Steers (1977), in the presentation of his model of management concerns, emphasizes the role of management in the balancing of the needs of adaptation and innovation with the equally important organizational needs for stability and continuity of structure and process. Given the non-routine work flow of a CMHC, a predominantly turbulent environment and the increasing scarcity of resources, this issue is believed to be of increasing significance and importance.

Rosner (1968) and Lynton (1969) both address the subject of organization control and innovation. Rosner (1968) suggests that an organization may be used as a tool to achieve goals and ensure reliability and predictability within the organization. At the same time, innovation facilitates the organization's adaptation to its environment and also facilitates goal achievement. Two pressures are identified: a pressure toward control as
the organization attempts to reduce uncertainty and enhance predictability, and a related pressure toward innovation. As control, particularly control of activity, increases, innovation decreases. An inter-play occurs between stability and change.

Innovation, however, may be contingent on other factors not identified by Rosner (1968), such as technology and the degree of turbulence present in the organizational environment. This is consistent with both Primary Proposition A and Primary Proposition B, emphasizing both a non-routine work flow and current turbulent field conditions. Rosner (1968) relates visibility of consequences to innovation, where visibility of consequences is defined as the ability or willingness to measure the consequences of organizational programs with organizational goals. It is suggested that when measures are introduced to check consequences, the propensity to innovate increases. It is strongly suggested that the Director of a CHMC selectively implement administrative controls which do not stifle the propensity to innovate. The turbulent environment and diverseness in treatment modalities within a CMHC suggest both an opportunity and capacity to innovate. Only the motivation remains which may well be facilitated by the Director.

Lynton (1969) examines organizational structure within the context of a turbulent field (Primary Proposition B). In a turbulent field a CMHC must innovate in order to maintain equilibrium. At the same time Primary Proposition B suggests an increasing differentiation of the organization into specialized sub-units. A need for integration is expressed. Lynton (1969) suggests that if the need for change in response to turbulence is assessed, permanent and innovative sub-units may be institutionalized,
legitimized and, with the assistance of integrating devices, become part of an organizational structure which is permitted to retain its predictability and reduction in uncertainty.

A CMHC may well assess a program relating to learning disabilities as requiring a rapid change in response on a continuous basis, as the environment changes, with the development of new resources.

The staff assigned to this program from within the CMHC may well be permitted flexibility of response with a consensus from other segments of the staff that this is a unique and required service. Legitimization may occur at all levels. All that remains is to provide an integrative linkage between the innovative sub-unit and the organization as a totality.

**Influence of Setting on Administration**

A number of pragmatic considerations directly affect the relationship between the CMHC administrators and the staff of the organization. The majority of CMHC within the boundaries of our discussion are relatively small in size. With a small number of staff the administrator is very visible. There is an opportunity for him to model behaviour which is seen as desirable. A teaching function may be realized providing opportunity for direct support of appropriate behaviour. Whittington (1973, p. 61) discusses this factor when he states, "In a large mental health agency this model of leadership is totally inappropriate and if followed exclusively will result in the ruin of the agency."

A small size is also contributory to a high degree of role blurring and a requirement for a basic substitutability of function. Staff absences are more significant in maintaining direct service delivery. Intake procedures
must be known to all staff, including clerical support. The issue of "like pay for like work" is also a significant consideration when a psychiatric nurse, acting as an administrator, is paid only a token compensation for responsibility which takes in not only programs, but also accountability for the behaviour of other disciplines including psychiatry. Tensions are generated by the least paid member of the program staff having sole statutory responsibility for the service and staff aspects of the CMHC.

The type of staff employed at the CMHC also affects the relationships between administrator and other employees. Program staff who are fully accredited within their respective discipline are expected to maintain appropriate standards of practice. The administrator will not be required, generally, to supervise clinical performance. However, with the increasing diversity of non-professional disciplines who lack internalized standards of practice, there is a demand for a supervisory role for which the majority of administrators lack preparation.

With an emphasis on a functional team organization with unit control, the existence of separate disciplinary lines are a source of tension. As discussed by Blau and Scott (1966), the degree of organizational loyalty is greatly affected by the degree of disciplinary identification. The existence of disciplinary consultants with the objectives of furthering unique disciplinary identification creates an additional burden on the administration of a CMHC. The integrity of the organization is placed in jeopardy.

Blau and Scott (1966) discuss at some length the relationship between employee identification with an organization and the degree of which they are affiliated with disciplinary groupings. Mental Health Programs
rely to an extent on professional associations to monitor clinical competence and provide for the inculcation of appropriate ethical standards in relation to both colleagues and clients. Professionally identified treatment goals and organizational goals are often inconsistent. A committee recently formed within Mental Health Programs; the Standards of Practice Committee has recently produced a draft copy of expected ethical and practice standards to be adhered to by all employees. Perhaps the organization will subsume some functions previously held by disciplinary and professional groupings (see Appendix 5).

Public agencies such as the CMHC are not as accountable as private agencies on methods of optimizing the productivity of staff. The public agency with its limited compensation for placement in geographically isolated areas must emphasize staff satisfaction as a way of retaining personnel. Lack of vertical mobility and absence of career leaders in CMHC is also significant in considering the need to emphasize staff satisfaction and maintenance goals.
Chapter 11

CONCLUSION

The Community Mental Health Centre - A Status Report

To a degree, many of the weaknesses pervasive through the Community Mental Health Centre system, stem from the strengths which keep it visible and significant in communities through the Province. A fundamental strength easily identified is the holistic approach offered to the individual, his family and the community in which he resides. The orientation of each professional lends itself to this consideration which is further enforced by the multi-disciplinary team which focuses in a concerted fashion on the multi-faceted aspects of the problems presented by the patient. Leopold (1974, p. 186) states, "Surely no one will deny that a fundamental strength rests in its view of the individual and his problems, a view that takes into account both the internal and external forces that contribute to his existence and includes hopefully, much that is relevant in the thinking of medicine as well as all other disciplines that concern themselves with human well being." Unfortunately, this holistic approach with its accompanying highly abstracted mandate (see Appendix 6) as expressed by Mental Health Programs, lends itself to a marked diffusion of effort on the part of staff as they attempt to treat a total problem which may range from delinquency to cleanliness. The multiple causation of mental illness make the identification of single interventions quite impossible.
The vague but inexorable pressure to align mental health professional with preventative activity adds fuel to the diffusion of effort. Leopold (1974, p. 187) states emphatically, "No one questions the desirability of prevention, but unfortunately, no one knows in the context of mental illness, what it really means how to do it or how to measure it." Yet, many professionals, feel obligated to allocate a significant amount of their time to activities which they feel relate to prevention.

The catchment area concept which was initially established to facilitate a focus for mental health effort remains a mechanism which was also established to return patients to their own communities in an orderly fashion. Unfortunately, catchment area boundaries bear little relationship to either health or welfare funding or planning units. Little regard was given to the location of other functional boundaries. The result is that in many catchment areas there is a shortage of other human service agencies other than the Mental Health Centre.

Unfortunately, efforts to evaluate the structure and process of Community Mental Health Centres is more than often done on the basis of the evaluator's own feeling of what a Community Mental Health Centre should be doing, perhaps in areas of social action. Perhaps, in summary, the Community Mental Health Centre displays its greatest weaknesses in failing as a broad spectrum social welfare agency due to lack of resources, and secondly, diverting clinical time to accomplish defined objectives of other human service agencies. In some ways the Community Mental Health Centre has by default moved from a health care system to a social welfare oriented service. Removing the Community Mental Health Centre from a welfare delivery orientation and placing it in closer proximity to the existing health care
system may well be the most viable organizational strategy at this point in time.

The implications for the existing default model of non-medical administration would suggest a high degree of resistance as the technologies these professionals employ would be of less utility in relation to the changing objectives of the CMHC. The power base of the non-medical support staff would be severely eroded. The continual problem of psychiatric service availability would have to be addressed with some new system of inducement established. Current organizational changes with the appointment of an Executive Director of both MH programs and Riverview Hospital would suggest a possible increased availability of both nursing and medical staff who might relatively easily accept an increased community responsibility.

The problem of dimensions, control and territory remain. Leopold (1974, p. 202), sums up and states, "We have all learned perhaps to our personal dismay, that he who is in charge of the purse strings is, in fact, in charge. The community mental health administrator is in a uniquely favourable position to make use of his hard won knowledge as he attempts to bring about the integration of his facilities with those of the general health system."

Broad Planning Implications

The administrators of mental health programs are confronted with pressures toward innovations and change. The success of any program is largely determined by the management of the change process. A number of factors have contributed to this process not the least of which is the rapidly increasing varieties of technology available to mental health
professionals. The increasing diversity of demand and the subsequent diversification of service is a reflection of the quest for individualized services tailored to each client requesting service. Feldman (1974, p. 290) remarks on the pervasiveness of the change process, "Within the field of mental health, it might seem that major trends have come slowly enough: moral treatment, custodialism, psychoanalysis, community mental health. But closer examination reveals that innovations, if not other varieties of change, has become a way of life within mental health organizations."

Two rather general propositions have been generated: the proposal that the work flow in CMH is non-routine and secondly that current environmental field conditions are turbulent. Both of these proposals reflect a high degree of uncertainty when considering the planning process.

Given a non-routine work flow and the relative contrast with organizations such as Public Health there is less opportunity for programmed direction of staff. The non-routine work flow combined with the relatively small size of the organizational unit mediates against high specificity in the application of rules and regulations. Immediate questions such as the feasibility of "integration" with the Public Health system must be viewed within this perspective. It is quite feasible to suggest the applications of mechanisms to facilitate program integration. Indeed this form of integration may indeed be inevitable reflecting scarce environmental resources. Co-ordinating bodies rather than a single individual would likely be a reasonable first step in achieving initial program and resources sharing accompanied by a more valid planning process based on increased information flow.
Administrative integration must result from the increased interface of programs. Issues of territoriality and domain are of paramount importance. To impose a more structured and programmed management system may if introduced rapidly result in the decreased flexibility of CMHC's to respond to non-routine demand both inter- and intra-organizationally.

Turbulent environmental field conditions further suggest co-ordinating mechanisms perhaps on a regional basis with regional boundaries co-terminous with boundaries established for other groups within the Health Ministry. The increased importance of boundary spanning personnel must be stressed in order to accommodate an orderly planning process with a concurrent reduction in uncertainty. Increased program interfaces within the Ministry of Health are further reinforced.

The change process at present would appear to suggest a decentralized, regional model of co-ordinated health care delivery. The evolution of CMHC has produced 33 autonomous units, each with their own administrator. The current Regional Director structure was predicted largely as the increasing span of control of the Co-ordinator of Mental Health only. A regional concept with regional health care resources co-ordination combined with coterminous catchment area boundaries would seem to be a rational option.

From this base a greater delineation of programs within the health delivery system may be possible. A refinement of areas of responsibility based on similar criteria would reflect an increasing consistency with a programmed budgetting system, currently being piloted in several ministries. An operational and functional mandate for CMHC's may be possible utilizing this foundation.
BIBLIOGRAPHY


Selig, A. "Why" and "How" to make Interdisciplinary Teams Work. 


APPENDIX 1

CMHC PROGRAM OUTLINES

Assessment and Diagnosis Program

This program provides for direct examination and assessment, by Mental Health professionals of several disciplines, both of individual Mental Health Centre clients and of clients of other agencies. Assessment and diagnostic services are provided to adults, adolescents and children who receive treatment from the Mental Health Centre and to clients referred by other agencies (e.g. Human Resources, Public Health, Education, Corrections, etc.). Examples of services included are: social assessment, behavioural assessment, developmental level assessment, psychiatric assessment, and psychological assessment.

The objectives of this program are: to aid in the development of a treatment plan for clients, and to provide a specialized support service to community agencies.

Community Educational Program

This is a program of educative and training services provided to groups of individuals at all age levels within the community. People receiving these services may be experiencing some difficulties in dealing with a particular area in their life situation, such as parenting or marriage. Typically the problems are not yet of the magnitude to require counselling or therapy. Services in this program are often provided in a formal education course fashion or in workshops. Examples of included services are: communication workshops, effective parenting education and family life training.

Objectives of this program are to help individuals deal with problems of life and to prevent problems of relatively low intensity from developing into disabling proportions.

Community Support Program

This is a program of development and support of community services. Special needs groups, such as single parent, senior citizens and other self-help
groups, are developed and/or supported in their work. In this program the Mental Health Centre serves as a catalyst for broad back-up of a community service rather than as a provider of direct service. Examples of services are: referral and advocacy, development of self-help groups and information.

Objectives of this program are to help individuals with problems of life to work together and help each other deal with their situation, to prevent these problems from becoming disabling, and to work with the community agencies to develop new resources to meet identified community needs.

Consultation Program

This is a program primarily to other agencies. Advice and/or "prescriptions" regarding clinical procedures, therapy techniques and treatment modalities useful in helping a particular client or general type of presenting problem is provided to community agencies (e.g. Human Resources, Public Health, Education, Law Enforcement and Corrections, Hospitals, etc.). Examples of services are: problem identification, therapy methods, alternate resources, and program development and evaluation.

Objectives of this program are to support other community resources in providing services by discussion of data supplied by the personnel of those community resources, and to increase the skill level of other professionals and nonprofessionals.

Counselling Program

This is a program of counselling services provided to individuals, couples and family groups. The adults, adolescents and children who receive these services are suffering from social, emotional or behavioural problems which are disruptive but not disabling enough to require intensive psychotherapy. Individuals suffering from marital conflict, parent-child conflict, developmental crises, self-doubt and other problems in living may receive counselling. Examples of included services are marital counselling, post-separation counselling, retirement counselling, identity counselling and pre-marital counselling.

The objectives of this program are improved functioning on the part of individual clients and avoidance of further personality disorganization which would require more intensive services.

Group Therapy Program

This is a program of therapy services directed primarily toward groups of clients. The adults, adolescents and children who receive services from
this program usually do not include those most acutely disturbed and out of touch with reality. They do, however, need ongoing treatment for emotional, social or behavioural problems. Examples of treatment services include: family therapy, social group therapy, marital or family therapy, full or part-time day programs, and activity groups.

The objective of this program is improved functioning on the part of individual clients, improvement in personal relationships and improvement in personal comfort.

Individual Therapy Program

This is a program of therapy services directed primarily toward individuals. Adults, adolescents and children receive these services for help with severe emotional, behavioural and social problems. Individuals receiving these services are usually diagnosed as being in some state of acute distress, requiring intensive and/or long-term treatment. Individuals suffering from psychoses, depressions, anxieties and life-stress reactions would all likely receive services from this program. Examples of treatment services included in this program are: uncovering or interpretive psychotherapy, reality therapy, desensitization, behaviour modification, supportive psychotherapy, role therapy, play therapy and crisis intervention. Any or all of these might be combined with chemotherapy, or supervision and adjustment of medications may be the main treatment focus.

The objective of this program is improved functioning on the part of individual clients, together with improvement in self understanding and personal comfort.

Rehabilitation Program

This is a program of treatment services for adults and occasionally adolescents with a history of disabling mental illness. Both individual and group treatment are employed. Persons requiring this program may be those released from an institution or those who for other reasons have lost daily living skills, work skills and habits, general confidence in their ability to re-enter the normal world of work and/or family and community life. Examples of services are: the provision of goal directed activity programs, occupation therapy, work-oriented motivation therapy, sheltered employment.

The objectives of this program are to assist the client to gain confidence to assume and enjoy a responsible, contributing mode of living within the community.
Research and Evaluation Program

This is a program of feedback services provided to clinicians and administrators. Hard and soft data research studies and process and outcome evaluation studies provide feedback on centre functioning. Services included are: awareness, attitude and incidence surveys, therapeutic effectiveness research and demonstration project evaluation.

Objective of this program is to improve the quality of services provided to clients and the community.

Residential Program

This is a program of services for adults. Individuals receiving these services are usually suffering from long-term disabilities, but may also be persons not yet chronically disabled who may or may not have received inpatient treatment who require a supportive, growth-promoting environment to enable them to resume an interrupted life or to confidently enter normal community life. Services include: supervised boarding homes, long and short term, providing levels of appropriate program, monitored apartment living, monitored independent group living, and regular supervision of the use of medications.

Objectives of this program are to provide an environment designed to help clients to reach and maintain their optimal level of functioning; to prevent admission or readmission to inpatient facilities and to re-integrate clients into the normal community.

1Mental Health Programs Policy Manual.
MEDICAL SPECIALIST and/or ADMINISTRATOR 2

Characteristics of Position

Employees in this position with the Public Service are under the administrative direction of the Deputy Minister or Associate Deputy Minister or senior medical officer and are responsible for the supervision of medical and para-medical personnel of a small division or a specialized service or clinic as public health unit directors with certification in Public Health; and as directors of mental health centres; or are consultants as designated by the Deputy Minister; other related duties as required. This is the working level for experienced medical specialists.

Qualifications Required

1. Education and Specialized Knowledge

Graduation from a medical school of recognized standing with a degree of Doctor of Medicine, or the equivalent, registration in the College of Physicians and Surgeons of British Columbia; certification in an applicable specialty by the Royal College of Physicians and Surgeons of Canada.
2. **Experience**

Considerable related supervisory or administrative experience for executive administrators; a minimum of two years or more of experience in the field of specialty subsequent to specialist certification.

3. **Specialized Abilities and Skills**

Mature judgment; flexibility in dealing with problems; ability to direct and utilize professional staff; ability to engage in public speaking; considerable administrative ability.

April 1, 1975 (New Classification)
Civil Service Commission
Victoria, B.C.

GROUP "PR" – PROFESSIONAL

Class 12 - Sociological and Psychological

SOCIAL WORKER - PSYCHIATRIC 3

Characteristics of Position

Employees in this position are under the direction of a Senior Social Worker and are involved with treatment responsibilities of special complexity and difficulty and assignment to more demanding clinical roles requiring use of advanced skills.

They are assigned more difficult responsibilities as a regular, recurring duty; assume assignments of a research and experimental nature, extending their skills into newer areas such as development of special therapeutic groups; handle difficult patients and families where sensitivity to accurate timing, appropriate technique and manifestations of illness are of vital importance; work with patients who particularly reject treatment or may be a hazard to themselves and others; may work in cases where extra skills in community organization, interpretation, consultation, and co-ordination are required.

They are responsible for carrying out a full social work contribution into team practices and extending that contribution to its maximum, while maintaining a sound relationship to the various responsibilities and roles of other team members. They have particular responsibility for reporting back and identifying needs and trends that will aid in planning, staff and programme development and policy changes.

Qualifications Required

1. Education and Specialized Knowledge

A Master of Social Work degree from an accredited School of Social Work; a sound theoretical knowledge of case work and group work practices and must have demonstrated excellent practice skills with considerable capacity for originality and resourcefulness.
2. **Experience**

Several years' experience in a recognized psychiatric or medical setting, or in a related treatment-focused social agency setting.

3. **Specialized Abilities and Skills**

Tact; sound judgement; ability to obtain confidence of patients and families; ability to work well with other professions and community representatives; advanced skills in social treatment, expert timing and alertness to manifestations of illness so as to bring them appropriately to medical attention; ability to maintain an objective interest in people and a demonstrated ability to work with them.
Civil Service Commission
Victoria, B.C.

GROUP "PR" - PROFESSIONAL

Class 12 - Sociological and Psychological

SOCIAL WORKER - PSYCHIATRIC 4

Characteristics of Position

Employees in this position are under the direction of a Chief Social Worker and are required to oversee a social work programme carried out by a group of social workers in a particular programme area of a hospital or clinic.

They are responsible for the social work programme and standards of performance in their programme area. Duties include giving supervisory guidance to staff; maintaining effective case flow and case management and developing good team inter-relationships; co-ordinating their programme within the hospital or clinic; developing good working relationships with representatives of community agencies; in co-operation with the Chief Social Worker and other administrative officials, carrying out staff development programmes, evaluating staff and programme needs, and developing new policies and procedures; taking responsibility for hospital and clinic relationships to Social Agencies and participating in community interpretation.

Qualifications Required

1. **Education and Specialized Knowledge**

   A Master of Social Work degree from an accredited School of Social Work; expert knowledge and skill in social work.

2. **Experience**

   Several years' suitable experience in a recognized psychiatric or medical setting; in a related treatment-focused social agency setting.
3. **Specialized Abilities and Skills**

Tact; sound judgement; ability to plan a social work programme and to give leadership to its effective operation and development; ability to co-ordinate with other disciplines and with overall programme; ability to make professional decisions quickly on the basis of limited knowledge; supervisory ability; ability to interpret services and policy and maintain good liaison with the community; ability to maintain an objective interest in people and a demonstrated ability to work with them.

1.466 (new position)
Civil Service Commission  
Victoria, British Columbia

GROUP "PR" - PROFESSIONAL

Class 12 - Sociological and Psychological

PSYCHOLOGIST 3

Characteristics of Position

Employees in this position are responsible either for the provision of psychological services in a Mental Health unit under the general direction of a director, or for the management of psychological services in a smaller functional unit of a larger psychiatric facility. They are required to collaborate closely with either junior psychologists for whom they are administratively responsible, or with other professional disciplines in the unit or in other community services and agencies in the planning and organization of programmes and are involved in rendering services in some, but not necessarily all, of the following areas: (a) Appraisal - The provision of an assessment service for psychodiagnosis, re-evaluation following therapy and appraisal of psychological resources of both/either adults and/or children; the supervision of junior psychologists in the use of and in the preparation of written reports based on standardized psychological methods, projective techniques, psychophysical tests, and other professional judgments, any number of which constitute an assessment service. (b) Therapy - The provision of programmes of therapy pertinent to patients of different ages, and differing disturbances, with close medical and/or psychiatric collaboration; the supervision of junior psychologists in conducting clinical interviews, play therapy, group therapy, individual therapy, and operant therapeutic techniques, any number of which might constitute such a therapy service. (c) Rehabilitation - the provision of an educational and vocational counselling service in collaboration with other agencies and/or other unit departments for placement, selection, and/or vocational training; the supervision of junior psychologists both in the use of standardized psychological methods relating to the assessment of aptitudes, interests, achievements, and other pertinent attributes, and in the rendering of educational or vocational counselling based on these methods. (d) Education - The organization of and/or participation in the development of community Mental Health education, in-service training, workshops, and institutes. (e) Consultation - The provision of a consultative service to community services such as welfare agencies, school-boards, correctional institutes, and Mental Health associations who would benefit from such professional assistance; the provision of a consultative service to other unit departments in regard to such matters as personnel recruitment, placement, selection, job analysis and merit-rating.
Qualifications Required

1. Education and Specialized Knowledge

Graduation from a university of recognized standing with a Master of Arts degree in psychology or an equivalent degree.

2. Experience

A minimum of five years experience in the supervised practice of psychology in psychiatric facilities following graduation, of which one year has been in a senior capacity. One year's credit may be granted for those who have satisfied all conditions for the Ph.D. or equivalent degree except for the dissertation requirement. One year's credit may be granted for the successful completion of a one year predoctoral internship programme.

3. Specialized Abilities and Skills

Sound organizational skills; proven ability in implementing policies and procedures; ability to supervise.

1.9.70
GROUP "PR" - PROFESSIONAL

Class 12 - Sociological and Psychological

PSYCHOLOGIST 4

Characteristics of Position

Employees in this position are responsible either for the provision of psychological services in a Mental Health unit under the general direction of a director, or for the management of psychological services in a smaller functional unit of a larger psychiatric facility. They are required to collaborate closely with either junior psychologists for whom they are administratively responsible or with other professional disciplines in the unit or in other community services and agencies in the planning and organization of programmes and are involved in rendering services in some, but not necessarily all, of the following areas: (a) Appraisal - The provision of an assessment service for psychodiagnosis, re-evaluation following therapy and appraisal of psychological resources of both/either adults and/or children; the supervision of junior psychologists in the use of, and in the preparation of, written reports based on standardized psychological methods, projective techniques, psychophysical tests, and other professional judgments, any number of which constitute such an assessment service. (b) Therapy - The provision of programmes of therapy pertinent to patients of different ages, and differing disturbances, with close medical and/or psychiatric collaboration; the supervision of junior psychologists in conducting clinical interviews, play therapy, group therapy, individual therapy, and operant therapeutic techniques, any number of which might constitute such a therapy service. (c) Rehabilitation - The provision of an educational and vocational counselling service in collaboration with other agencies and/or other unit departments for placement, selection, and/or vocational training; the supervision of junior psychologists both in the use of standardized psychological methods relating to the assessment of aptitudes, interests, achievements, and other pertinent attributes, and in the rendering of educational or vocational counselling based on these methods. (d) Education - The organization of and/or participation in the development of community Mental Health education, in-service training, workshops, and institutes. (e) Consultation - The provision of a consultative service to community services such as welfare agencies, schoolboards, correctional institutes, and Mental Health associations who would benefit from such professional assistance; the provision of a consultative service to other unit departments in regard to such matters as personnel recruitment, placement, selection, job analysis and merit-rating.
In addition to the above management and supervisory functions, the employees may be called upon to initiate or may themselves initiate or delegate with direction, the design of research and its statistical analysis relating to problems of a psychological nature.

Qualifications Required

1. **Education and Specialized Knowledge**

Graduation from a university of recognized standing with a Doctor of Philosophy degree in Psychology or an equivalent degree.

2. **Experience**

A minimum of three years experience in the supervised practice of psychology in psychiatric facilities following graduation, of which one year has been in a senior capacity. One year's credit may be granted for the successful completion of a one year pre-doctoral internship programme. Credit of one or more years may be granted in lieu of experience accumulated in the supervised practise of psychology in psychiatric facilities subsequent to the completion of an M.A. or equivalent degree acquired earlier.

3. **Specialized Abilities and Skills**

Sound organizational skills; proven ability in implementing policies and procedures; ability to supervise.

1.9.70
ACTIVITY WORKER 3

Characteristics of Position

Employees in this position are under the supervision of an occupational therapist, senior activity worker or other institutional official and are:

a) Under general direction required to independently operate a limited or medium sized activity program. Supervision of Activity Worker 1 or 2 may be involved.

or

b) Under immediate direction performing at the working level in a program requiring the supervision of patients involved in the regular operation of complex and dangerous equipment.

c) Under minimal direction functioning as assistant director of an extensive program. Supervision of junior activity workers is normally required.

Duties include those required of Activity Workers 2 plus planning, executing and assessing the program; training and direction of Activity Workers 1 and 2, and other related duties as required.

Qualifications Required

1. Education and Experience

   (a) Two years as Activity Worker 2 or equivalent.

   or (b) University graduation in appropriate disciplines, preferably with some related experience gained working
with residents of type involved in the particular institution, or via working with community groups or volunteer agencies.

2. Specialized Knowledge

A highly developed level of personal proficiency in the trade, skill, craft or technique applicable, familiarity with teaching methods; some knowledge of the therapeutic value of the particular activity. Possession of the appropriate Driver's Licence, lifeguard qualifications, or other licence or certificate may be required.

3. Specialized Abilities and Skills

Ability to stimulate residents' interest, assess results of the program and work effectively on an individual or group basis; ability to adapt to changing roles and program requirements; ability to exercise tact and good judgment; ability to work effectively with institutional staff, volunteers, residents, and the general public.

September 1974   (To replace Recreational Therapists, Handicraft Instructors, Hospital Tutors, Instructors - Rehabilitation)
Components: Occupational Therapist 1

Characteristics of Position

Employees in this position are under the direction of the Occupational Therapist-in-charge and/or the medical staff and are required to instruct and supervise up to thirty patients in a mental hospital, contagious disease hospital, or infirmary, in several handicrafts such as sewing, hemstitching, embroidery, knitting, needlepoint, wood-carving, pottery-making, plastic work, and shell-work; to consult with the Occupational Therapist-in-Charge and the medical staff in connection with assigning the patient to the particular occupation that would best aid his recovery; to observe and record the individual patient's progress; to instruct patients in the use of equipment used in the various handicrafts; to submit reports on the individual patient's progress recommending action necessary to improve his condition; may supervise the sale of articles made by patients; may be required to purchase or requisition for materials and equipment; may be required to supervise the work of Industrial Therapists; to perform related duties as required.

Qualifications Required

1. Education and Specialized Knowledge

   Graduation from a university or an approved school with a degree or a diploma in Occupational Therapy or Rehabilitative Medicine; a good knowledge of occupational therapy principles and techniques, and the operation and care of related equipment and minor maintenance.

2. Experience

   Preferably some experience subsequent to formal training.
3. **Specialized Abilities and Skills**

Tact; sound judgement; ability to assist in the planning and direction of an occupational therapy programme in an institution; ability to estimate cost and value of materials; ability to deal with both physically ill and mentally ill patients.

**PROVISO**

Successful applicants with a minimum of one year's acceptable experience as an Occupational Therapist may commence employment in the second step of the salary range and those with a minimum of two years acceptable experience as Occupational Therapist may commence employment in the third step of the salary range.

1.4.70 (revised and transferred from Group "1E", Class 10)
Characteristics of Position

Employees in this position are under direction to perform work of a supervisory or specialized nature as senior nurse and direct assistant to the Head or Charge nurse, or to perform specialized nursing services of a comparable degree of complexity.

Duties may include responsibility, in the absence of the head nurse, for ward management and supervision of patients and staff; assisting in the development of a programme of total nursing care of patients or residents in a designated area; assigning duties to all area personnel and assisting in their supervision; participating in the orientation and training of staff; assisting in arranging schedules, writing reports; and maintaining nursing records; assisting with technical procedures and treatments and preparing and operating equipment; or carrying out specialized nursing duties in a clinical setting, war, or programme involving special treatments, experimental therapy, intensive care, or therapeutic nursing care; or assisting in the public health nursing service in a health unit; keeping abreast of developments and changes in nursing techniques; performing other related duties as required. Positions in this category are determined on an establishment basis relevant to staff numbers, length of patient stay and movement, intensity and complexity of programme; or on the requirement to assist with the day-to-day management of a ward or programme.

Qualifications Required

1. Education and Specialized Knowledge

   Eligible to practise nursing in the province of British Columbia under the Registered Nurses and/or Psychiatric Nurses Acts; preferably a recognized course in administration or clinical specialty relevant to the position.

2. Experience

   A minimum of two years satisfactory experience or one year in the particular specialty or area with an approved relevant course.
3. **Specialized Abilities and Skills**

Sound judgement, tact, high standards of integrity and responsibility; ability to meet and deal with the public; ability to prepare and maintain records, charts and reports; ability to supervise and instruct staff.

**Proviso**

Nurses who have successfully completed approved appropriate clinical and university courses may be paid an amount in addition to the salary assigned to the position.

(Replaces Staff Nurse 2 and Assistant Charge Psychiatric Nurse)

1/4/73
Civil Service Commission
Victoria, B.C.

"PR" - PROFESSIONAL
Class 10 - Nursing

NURSE 5

Characteristics of Position

Employees in this position are under general direction to supervise the total nursing services provided through a group of wards comprising a small unit; or to assist in the administration and supervision of nursing services of a large unit; or to be in sole charge during afternoon and night shifts of a large institution or hospital; to be responsible for nursing services in a highly technical area or clinic.

Duties may include directing nursing and auxiliary personnel and co-ordinating inter-departmental services; organizing and administering an educational programme for staff and patients; maintaining adequate staff and equipment; carrying out personnel administration and policy; maintaining staff records and preparing reports on nursing service and its requirements; promoting and encouraging inter-departmental relationships; keeping abreast of developments and changes in nursing services; deputizing for a superior where the position normally requires assistance in the administration of a large unit and performing other related duties as required.

Qualifications Required

1. Education and Specialized Knowledge

   Eligible to practice nursing in the province of British Columbia under the Registered Nurse and/or Psychiatric Nurse Acts, preferably recognized courses in administration, appropriate clinical specialty or university diplomas in nursing relevant to the position.

2. Experience

   Several years nursing experience including two years in a supervisory capacity as a Head Nurse or equivalent.

3. Specialized Abilities and Skills

   Sound judgment, tact, high standards of integrity and responsibility; ability to meet and deal with the public; knowledge
and ability in personnel management; ability to write reports; and ability to supervise and instruct a large staff.

Proviso

Nurses who have successfully completed approved appropriate clinical and university courses may be paid an amount in addition to the salary assigned to the position.

(Replaces Superintendent of Nurses 2 and Chief Psychiatric Nurse 2)

1/4/73
COMPONENT 50: SOCIAL, EDUCATIONAL & HEALTH SERVICES

GROUP 3: SOCIAL & HEALTH SERVICES SUPPORT

CLASS 471

CASE AIDE

Characteristics of Position

Employees in this position perform duties as a member of Field Service staff in the District Social Welfare Offices or in other offices in the Department of Social Welfare.

They work under the immediate direction of a District Supervisor or senior social worker and are required to assist social workers and carry out delegated duties relative to Social Assistance, Child Welfare, ancillary services, and related work assigned according to the policies and procedures pertaining to the general social welfare services of the Department.

Qualifications Required

1. Education and Specialized Knowledge

Secondary School Graduation or equivalent; preferably completion of at least one year of a Social Welfare Aide course in a recognized University or College.

2. Experience

Preferably some experience in meeting the public or in allied fields; must be at least 21 years of age and hold a valid driver's licence.

3. Specialized Abilities and Skills

Ability to maintain an objective interest in people, and a sympathetic understanding of their problems; tact and sound judgement; ability to use community resources; ability to express themselves in writing as well as orally; ability to drive an automobile.

Proviso

Suitable applicants who have completed a two year Social Welfare Aide Course at a recognized University or College may commence at step 2 of the salary range of this position.

1.6.68 (replaces Welfare Officer)
APPENDIX 3

PUBLIC HEALTH POLICY - MENTAL HEALTH SERVICES, 1972

I. SERVICES AND FACILITIES OF THE MENTAL HEALTH BRANCH

The mental health services of the Province are administered by the Mental Health Branch of the Department of Health Services and Hospital Insurance under the supervision of the Deputy Minister of Mental Health. The office of the Deputy Minister is situated at 1019 Wharf Street, Victoria, B.C.

MENTAL HEALTH BRANCH FACILITIES

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Telephone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Riverview Hospital, Essondale, B.C.</td>
<td>521-1911</td>
</tr>
<tr>
<td>Valleyview Hospital, Essondale, B.C.</td>
<td>521-1911</td>
</tr>
<tr>
<td>Dellview Hospital, Vernon, B.C.</td>
<td>542,3011</td>
</tr>
<tr>
<td>Skeenaview Hospital, Terrace, B.C.</td>
<td>635-2265</td>
</tr>
<tr>
<td>The Woodlands School, New Westminster, B.C.</td>
<td>521-2611</td>
</tr>
<tr>
<td>Tranquille School, Tranquille, B.C.</td>
<td>376-3361</td>
</tr>
<tr>
<td>British Columbia Youth Development Centre, 3405 Willingdon Avenue, Brunaby 2, B.C.</td>
<td>434-4247</td>
</tr>
</tbody>
</table>
### MENTAL HEALTH CENTRES

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnaby</td>
<td>3405 Willingdon Avenue</td>
<td>434-4247</td>
</tr>
<tr>
<td>Chilliwack</td>
<td>45470 Menholm Road</td>
<td>795-5706</td>
</tr>
<tr>
<td>Courtenay</td>
<td>480 Cumberland Road</td>
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A. RIVERVIEW HOSPITAL

This is an active and continued treatment hospital for all forms of mental disorder requiring institutional care and treatment.

**Procedure for Admission**

Crease unit is the admission and active treatment facility for patients from the Great Vancouver area.

Centre Lawn unit is an admission and active treatment facility for male and female patients coming from any where in the province except the Greater Vancouver area. All new patients from provincial health unit areas are admitted to Centre Lawn.
All admissions to Riverview Hospital, other than those referred under special sections of the Criminal Code of Canada by Order-in-Council or Magistrate's Warrant, are governed by the provisions of the Mental Health Act, 1964 which may be consulted for detailed information.

Admissions may be on one of the following basis:

1. Informal Admission

Suitable for patients who are well motivated and accepting of hospitalization and are capable of understanding their need for in-patient care and treatment. No specific form is required but it is necessary that the referring physician contact the Admitting Officer (Riverview Hospital) by telephone or letter outlining his reasons for recommending admission and to indicate that he has, in fact, "examined the patient and is of the opinion that he is mentally disordered."

In many areas served by provincial health units informal admissions are now made to psychiatric units in the general hospital serving the community.

2. Involuntary Admissions

For all patients not suitable for "informal admission" this requires:

(a) A written application for admission (Form # M.H.A. 64/68/1) which should be completed and signed by a near relative or a peace officer or any person who has knowledge of the circumstances and has reason to believe that the person is mentally disordered.

(b) Medical certificates (Form # M.H.A. 64/68/2) completed by two physicians not in partnership and not near relatives of the patient.

Both the application and medical certificates must bear dates within fourteen days of admission to hospital. These forms are available in the local mental Health Centre and questions concerning admission of patients should be referred to the Mental Health Centre. In certain emergency situations a patient may be admitted for a temporary period of time on one medical certificate.
B. VALLEYVIEW HOSPITAL-DELLVIEW HOSPITAL-SKEENAVIEW HOSPITAL

These hospitals comprise the Geriatric Division of the Mental Health Branch. They provide treatment and care for persons over 70 years of age who suffer from a mental disorder arising from the aging process and whose behaviour is such that they cannot be adequately cared for elsewhere in the community.

Procedure for Admission

Valleyview Hospital, Essondale:-

Requests for admission are made by telephone or letter to the Superintendent's office by the person's physician or other person acting on his behalf.

Following this request in the Lower Mainland area, all persons west of Langley will be seen and assessed as to suitability or priority for admission. The physician will be given a report on the assessment and if the person is accepted for admission and a bed is not available his name will be placed on a waiting list and admitted as a bed becomes available.

The procedure for persons outside the Lower Mainland is the same but the person will not be seen for assessment.

Dellview Hospital, Vernon:-

For persons in the Okanagan, Kootenay areas the physician will call or write the supervisor of the hospital giving details of the person's illness and requesting admission. The supervisor will arrange admission as beds are available.

Skeenaview Hospital, Terrace:-

For male patients only in the northwestern area, the procedure for admission is the same as for Dellview Hospital.

1. Informal Admissions must be recommended by a physician and the person must be willing and able to sign an application and consent form.

2. Involuntary Admission the same procedure is followed as for involuntary admission of patients to Riverview Hospital.
C. THE WOODLANDS SCHOOL

This is a hospital-school which provides:

(a) Long term hospitalization for the severely retarded, with or without physical handicap.
(b) Inpatient training and habilitation facilities for the moderately retarded with or without physical handicap and/or mental disorder.
(c) Inpatient educational facilities for the mildly retarded with severe physical handicap and/or mental disorder.

There are three units:

(a) The Hospital Unit which admits physically and mentally handicapped.
(b) The Psychiatric Unit which treats those children whose mental retardation is accompanied by emotional or behaviour disorder. One example is the autistic child.
(c) The Training Unit - this unit provides education and/or training to the level of the individual's ability.

Procedure for Admission

When a request for admission is being considered, the individual and family concerned should first be discussed with the local mental health centre staff to ensure that they know the situation and concur with the decision to request admission.

1. Informal Admissions - This is the usual type of admission. When the decision to request admission has been reached in consultation with the Mental Health Centre, the worker involved should write to the Medical Superintendent enclosing a completed P.H. 48 - Rating Form for Woodlands School which is a guide in establishing priority. Individuals are admitted to the unit most suited to their need. There are waiting lists for all units and applicants are admitted on the basis of priority and the occurrence of a vacancy on the appropriate unit. There is no age limit or restriction re degree of retardation. Parents will be contacted by the Woodlands School and requested to complete the following:

a) Report of personal habits and training of patient at time of admission.

b) Three copies of a "questionnaire" form dealing with diagnosis, and wishes of the parent for admission, etc. One copy of this questionnaire is retained by Woodlands. One copy goes to Registry for Handicapped Children and Adults. One copy is returned to health unit for information only.
At the time of admission the parents will be requested to sign Authorization for Diagnostic and Treatment Services and a permission form which is prepared by The Woodlands School. The health unit will be requested to complete a Social Information Form (M.H.S. 241) as well as the P.H. 48.

When the Medical Superintendent receives an application for admission of a patient for whom there is not rating form on file, a letter is sent to the parents with a copy to the private physician stating that the local health unit may have additional social and other health information which will help assess the urgency of the admission, and that the application will be discussed with the health unit unless word is received to the contrary.

Following a two week wait, the health unit director is advised of the application, and a request is made to him for social or other information (with copy to local Social Welfare Office). A P.H. 48 - Rating Form for Woodlands School and Social Information form will be requested by Woodlands to be completed by the appropriate agency.

2. Involuntary Admission

This may occur when the individual is considered a danger to others and an emergency admission is required. The same forms are required as for an involuntary admission to Riverview.

3. Thirty Day Admission

A thirty day admission may be for the purpose of offering a mother some relief from the care of the retarded child and to permit a family vacation, or a complete assessment of the child. Ideally both purposes are served, but not all thirty day admissions receive a full assessment. Most thirty day admissions occur during July and August, when some children from the training unit are home on holiday. A special application form (M.H.A. 64/4 - yellow) should be completed by relatives.

Priorities for Admission

Priorities for admission are established to a large extent from the information provided on the P.H. 48 - Rating Form for Woodlands School. Instructions for completing this form are in Volume II of the Policy Manual. It is very important that a brief explanation be given for every rating other than "0". Frequently a child cannot be admitted at the first request or when the first rating form is submitted. When admission is urgent the P.H. 48 should be reviewed and revised as necessary to keep The Woodlands School informed of changing priorities.
Pre-admission Stool Specimen

A stool specimen must be submitted to the Division of Laboratories shortly before the admission of any child to the school. If a negative stool specimen report is not received by the school prior to the arrival of the child he will be detained in the isolation ward until the report arrives.

The Woodlands School will instruct parents to obtain a specimen container from the health unit and will provide the parents with a special requisition form stamped "Woodlands School Pre-admission Stool Specimen."

The Health Unit should make sure that the regular requisition form is removed from the stool specimen container before the container is given to the parents, and that the special requisition is properly completed, and placed in the container.

The laboratory report is sent directly to The Woodlands School.

Outpatient Department

This department provides complete assessment for the retarded child and adult also guidance to parents and consultation for other professional workers regarding the management of the child or adult in the home and community.

There are three assessment teams which correspond with the units to which the child or adult would be admitted if and when admission is considered. Each of these have outpatient clinic days as follows:

- Hospital unit - Monday
- Psychiatric unit - Tuesday
- Training unit - Thursday

Requests for appointments at Outpatients should be made to -
Superintendent, The Woodlands School

Attention - Coordinator Medical Health Services,
Outpatient Department

These requests should be made in writing - telephone requests are not accepted unless followed by a latter.

Sufficient information concerning the case should be provided to enable the Outpatient staff to determine in which of the three clinics the individual should be assessed. There may be up to six months wait for the appointment date depending upon how heavily booked the appropriate clinic is.
P.H.48 rating form is **not** required unless admission is being requested.

Assessment at Outpatients usually takes one day. In the morning (3-4 hours) the patient and parents are seen by the various team members; at 1:00 p.m. a conference of the team is held to discuss the assessment and recommendations; after this parents are given a verbal report on the assessment and recommendations.

Cost for Residential Care - The charge for maintenance is $1.00 per day up to the age of 16 years and $1.50 per day for those patients 16 years and over. The parents are also requested to supply clothing. The family's circumstances are taken into consideration. Questions concerning maintenance should be directed to the Collector of Institutional Revenues, 635 Burrard Street, Vancouver, B.C.

**Note:** - The final decision regarding admission rests with the Superintendent of The Woodlands School. All applications whether they emanate from a parent, relative, or agency should be forwarded to the Superintendent. Likewise all correspondence concerning admissions should be directed to the Superintendent.
APPENDIX 4

ADMISSION CRITERIA FOR
INPATIENT UNITS

An inpatient admission should occur only when 24 hour nursing supervision in a controlled, medically managed setting is required for:

1. a definitive diagnosis and the initiation of a treatment plan that require a range of diagnostic and treatment services available only in an acute facility.

2. deficit of judgment, inability to communicate, or behaviour that may result in self damage; is associated with a highly stressful situation; or that seriously contravenes social norms.

3. an overt attempt or threat of suicidal or homicidal behaviour.

Departure from these criteria should occur only when alternative, more appropriate care services are not available.
APPENDIX 5

CODE OF ETHICS - COMMUNITY MENTAL HEALTH PROGRAMS

The proposed would apply to all staff (professional and clerical), students and volunteers of Community Mental Health Programs.

Affirmation of Human Dignity

All Mental Health personnel, including students and volunteers, are committed to a belief in the dignity and worth of the individual human being.

Client's Acceptance of Services

The client is informed of any important aspect of the potential or existing therapeutic relationship that might affect the client's decision to enter or continue treatment. Specifically:

A. The client shall be made aware, as early as possible, of the treatment contemplated, the anticipated outcomes and possible concomitant reactions and consequences, an financial responsibilities.

B. The client has the right to know if he is being treated by an experimental procedure, and is given the opportunity to consent.

C. The client shall be informed of those limits to confidentiality which in the opinion of the therapist may affect the client's decision to continue or limit the relationship.

D. Where clients are considered incapable of evaluating their situation, it is advisable that persons deemed responsible for the client be informed of the above circumstances.
Confidentiality

The primary obligation of all staff members is to safeguard the privacy of clients.

A. No information about a client will be communicated to any other person or agency outside the mental health system, unless the following conditions have been met.

1. A signed release of information has been obtained from the client for the purpose of necessary information transfer;

   or when

2. Discussions and reports are limited only to those individuals known to have a clear professional mental health involvement with the client's case and need the information for relevant therapeutic purposes.

B. Unless client consent has been given, client information can be used in clinical discussions and instructional efforts outside the mental health system only when the identity of the individual has been disguised.

C. Confidentiality may be violated only when an immediate danger exists to the client and/or others.

D. Therapeutically irrelevant data and value judgements are not appropriate in clinical records.

Moral and Legal Expectations

A Mental Health staff member should show regard in personal conduct for the social codes and moral expectations of the community.

Therapist - Client Relationships

A. The therapist should have a personal concern for clients, but will always maintain professional and objective personal conduct between himself and the client and the client's significant others.
B. The therapeutic relationship should never include behaviours on the part of the therapist which would be abusive or damaging to the client.

C. The therapist will recognize his professional limitations and, when indicated, recommend to the patient that additional or alternate opinions and services be obtained.

D. Every effort must be made to discourage the development of personal obligations or acceptance of favours or gifts during the therapeutic relationship.

E. When there is a conflict among professional workers, the welfare of the client must take precedence.

F. The professional attempts to terminate or transfer a clinical relationship when it is reasonably clear that the client will not benefit from the existing relationship.

G. Care must be taken to insure an appropriate setting for clinical work to protect both client and therapist.

H. A therapist having pre-existing social ties or relationships with a person seeking service should carefully evaluate his capability to effectively treat the client, and discuss it with his supervisor prior to accepting responsibility.

I. Staff members take responsibility for the continuity of clients' care in the treatment, referral or follow-up process.

Relations with Colleagues

Respect for the rights and privacy of colleagues is maintained, specifically:

1. A client within the Mental Health Programs shall not be offered or given treatment without the knowledge and consent of his therapist, except in emergency situations.

2. Criticism of a colleague's services or procedures should only be directed to the colleague or through appropriate Mental Health Programs channels.
Individual Competence

The maintenance of professional standards of competence and quality of services is the responsibility of all Mental Health personnel. The following statements related to professionals apply to all Mental Health program staff, volunteers and students.

A. A mental health professional will offer services and use techniques that are generally acceptable, in terms of effectiveness and procedures, to professional judgement and to the community. Controversial issues shall be discussed with supervisory staff and meet with supervisory approval.

B. Each individual will be responsible for recognizing the limitations of his competence and will only provide services and use procedures in which he is technically competent.

C. Each person will continue his education to improve his standard of care.

D. Each professional should seek peer or supervisory advice for problematic issues of client management.

E. The professional avoids misrepresentation of his own professional qualifications, affiliations, and purposes, and those of the colleagues, institutions and organizations with which he is associated.

F. Modesty, scientific caution, and due regard for the limits of present knowledge characterize all statements to the public, either directly or indirectly.

6.IX.78
APPENDIX 6

MANDATE OF MENTAL HEALTH PROGRAMS

Philosophy

Mental Health Programs is committed to the concept of community-based services. The care of individuals within their own environmental situation and, whenever possible, within their own families, is considered preferable to hospitalization. Intervention at the early stages of the development of problems, and the mobilization and co-ordination of resources are accomplished more readily from a community-based service. The objective of community care is to provide the appropriate intensity of service within the context of the environment at the earliest possible point of intervention, reserving more extensive modes of care as back-up resources to be used if required.

Responsibilities

Services are available to any citizen and resident of British Columbia for any type of mental health problem and for any level of disturbance ranging from relatively mild life stress reactions through to relatively severe acute personality disorganization. In the provision of services regard is given to the services provided by other community agencies to avoid competing or overlapping services.

The responsibilities of Mental Health Programs include the provision of mental health services to adults, children and family units experiencing social, emotional, behavioural or mental distress in the community. Each mental health centre is also responsible for providing a consultation and support service to other community agencies. Similarly, the mental health centre provides education, information and other preventive services to the general community, and otherwise acts as an advocate of mental health in communities.
In general, the more acutely disturbed individuals in the community, regardless of age, sex or problem type, and individuals with a history of recurrent episodes of debilitating emotional states are important concerns.

Programs and Objectives

Crisis intervention, emergency treatment and consultation are available to all members of the community on a 24-hour basis. Existing staffing levels may, however, affect any one centre's ability to provide these services.

There are ten core service programs which must be available at all mental health centres. These ten programs and their objectives are:

- **Assessment and Diagnosis Program** - objectives are to aid in the development of a treatment plan for clients, and to provide a specialized support service to community agencies; Community Education Program - objectives are to help individuals deal with problems of life and to prevent problems of relatively low intensity from developing into disabling proportions;
- **Community Support Program** - objectives are to help individuals with problems of life to work together and help each other deal with their situation, to prevent these problems from becoming disabling, and to work with the community agencies to develop new resources to meet identified community needs; Consultation Program - objectives are to support other community resources in providing services by discussion of data supplied by the personnel of those community resources, and to increase the skill level of other professionals and nonprofessionals in dealing with mental health problems;
- **Counselling Program** - objectives are improved functioning on the part of individual clients or families and avoidance of further personality disorganization which would require more intensive services;
- **Group Therapy Program** - objective is improved functioning on the part of individual clients or families, improvement in personal relationships and improvement in personal comfort;
- **Individual Therapy Program** - objective is improved functioning on the part of individual clients or families, together with improvement in self understanding and personal comfort;
- **Rehabilitation Program** - objectives are to provide an environment designed to help clients to reach and maintain their optimal level of functioning; to prevent admission or readmission to in-patient facilities, to re-integrate clients into the community.

Priorities

Because of lack of resources, however, the mental health centre staff may have to assign priorities to each request for service. On a broader basis, program priorities are based on assessed needs within communities, and set for each catchment area in discussion with the Ministry.

D. Fernandez, Ph.D.
22/3/78