MILTON GREENBLATT

ADMINISTRATION OF THE STATE HOSPITAL

American Handbook of Psychiatry

Administration Of The State Hospital

Milton Greenblatt

e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 5* edited by Silvano Arieti, Daniel X. Freedman, Jarl E. Dyrud

Table of Contents

Administration Of The State Hospital

State hospitals are complex systems that function to admit, treat, and follow up mentally ill patients. They have also been used to segregate individuals who are dangerous to society, where the dangerousness may be attributable to emotional disorder. Many other individuals have been hospitalized who do not necessarily suffer full-blown mental derangement, but, inasmuch as they may be homeless and without friends and society provides no better place for them, they have been accepted on "humanitarian" grounds as inpatients.

Throughout history mental hospitals have varied dramatically in both structure and function while generally pursuing their social task of segregating and treating the emotionally disturbed. History, in fact, teaches us that the primary therapeutic methods and goals of our mental hospitals have largely reflected society's philosophical view of man and his willingness and ability to muster resources on behalf of the destitute, poverty-stricken, and downtrodden sector of humanity. The mentally ill in state hospitals constitute one of the disfranchised minority groups to which society now appears to be addressing itself with renewed vigor. Indeed, the mentally ill come from the poverty stratum; and the conditions of their hospitalization, throughout most of our nation's history, have reflected, again, poverty, discrimination, and neglect.

History

The *first hospital* for the mentally ill in America, founded in 1817 by Pennsylvania Quakers, was named the Friends Asylum. Patterned after the York Retreat, it was opened expressly for the purpose of practicing moral treatment—an enlightened form of patient care based on kindness, forbearance, and understanding together with social, recreational, and occupational diversions directed toward restoring balance in their lives. Many more privately endowed hospitals conducted along similarly enlightened lines were constructed in the ensuing years. The *first state-supported institution* was built in Lexington, Kentucky, in 1824, the Eastern State Hospital. It was followed in 1825 by the Manhattan State Hospital in New York; in 1828 by the Western State Hospital in Staunton, Virginia; in 1828, also, by the South Carolina State Hospital in Columbus; and the Worcester State Hospital in Massachusetts in 1833. State hospital construction burgeoned, particularly after 1841, when that Massachusetts school teacher, Dorothea Dix, aflame with anguish at the suffering and abuse of the mentally ill in the jails and almshouses, appealed directly to the legislatures of Massachusetts and other states to provide humane care and treatment for the afflicted. In 1904, the State Care Act in Massachusetts relieved the towns of their obligations for patient support in state hospitals; this, in turn, was followed by another large influx of patients into hospitals from jails and almshouses.

The early state hospitals of the moral treatment era were small communities in which close relationships existed among the superintendent, his staff and the patient population (Bockoven, 1972). The superintendent and his family, according to the description by Charles Dickens in 1842, sat down to dinner every day with the patients, whom they knew intimately and personally.

In the labor department, every patient is as freely entrusted with the tools of his trade as if he were a sane man. . . . In the garden and on the farm, they work with spades, rakes, and hoes. For amusement, they walk, run, fish, paint, read, and ride out to take the air in carriages provided for the purpose. They have amongst themselves a sewing society to make clothes for the poor, which holds meetings, passes resolutions, never comes to fisticuffs or Bowie knives as some assemblies have been known to do elsewhere; and conducts all its proceedings with the greatest decorum. . . . Immense politeness and good breeding are observed throughout. . . . It is obvious that one great feature of this system is the inculcation and encouragement, even among such unhappy persons, of a decent self-respect, (Dickens, 1842, pp. 105-111).

Thus, administration in the moral treatment era was directed to establishing within the hospital an enlightened society, with great respect for each individual. Careful attention was directed to his psychological and social needs, and opportunities were provided for occupational and social activities

of all sorts. The assumption was that the patient could be trusted, that he would get better, and that he could contribute both to the inner community of the hospital and eventually to the outer community. This optimism was reflected in actual statistics of improvement and discharge.

The philosophy, mission, and dedication of the superintendent was poignantly stated by Isaac Ray, superintendent of the Augusta State Hospital in 1873.

> He constantly striveth to learn what is passing in the mind of his patient, by conversation and inquiry of those who see him in his unguarded moments. He also maketh diligent inquiry respecting the bodily and mental traits of his kindred, knowing full well that the sufferer is generally more beholden to them than himself, for the evil that has fallen upon him. He endeavoreth so to limit the number committed to his care, as to obtain a personal knowledge of every wandering spirit in his keeping. He boasteth not of the multitude borne on his registers, but rather, if he boasteth at all, of the many whose experience he has discovered, whose needs he has striven to supply, whose moods, fancies, and impulses he has steadily watched. To fix his hold on the confidence and good will of his patients, he spareth no effort, though it may consume his time and tax his patience, or encroach, seemingly, on the dignity of his office. A formal walk through the wards, and the ordering of a few drugs, compriseth but a small part of his means of restoring the troubled mind.

Moral treatment did not survive the radical changes in the socioeconomic structure of the nation that came with the industrial revolution after 1860 (Greenblatt, 1955). Hospitals increased rapidly in size as population growth turned into its exponential phase. Patients were no

longer treated directly by the superintendent but by attendants, low in the hospital hierarchy, poorly paid, lacking in professional instruction or standards, and themselves handled impersonally by the ever-enlarging system in which they worked. Influx of foreign-born immigrants to our shores, who lived impoverished lives and frequently fell prey to emotional disorders, increased the inpatient population of hospitals. They were considered undesirable by the "intelligent yeomanry" of the early American villages; and as staff-patient ratios fell, so did wages of attendants and nurses in mental hospitals as compared to general hospitals. The most unfortunate consequence of all these developments was that as patients were increasingly treated as impersonal objects, discharge rates fell decade by decade so that some distinguished psychiatrists of the late 1800s, like Pliny Earle, began to argue that mental disease was becoming incurable (Pinel, 1806).

During this period new philosophical-intellectual themes were sounded. In the sphere of sociology, William Graham Sumner (1934) expounded on the theory of social Darwinism, which regarded social laws as fixed and immutable as physical laws; he advised strongly against support of the "hopelessly degenerate members of society" as a waste of effort and money. "Let it be understood that we cannot go outside this alternative: liberty, inequality, survival of the fittest; not—liberty, equality, survival of the unfittest."

In the field of medicine a great to-do was being made of so-called "lesions of the brain" associated with mental disorder. That these dicta came from the neuropathologist's bench carried great weight, for the science of neuropathology was being extolled as the last court of appeals in diagnosis. History has since demonstrated that although some of the damage noted in the brains of mental patients at post-mortem was due to cerebral nervous system syphilis, trauma, or encephalitis, nevertheless, most of the post-mortem changes were due to autolytic processes following upon the death of tissues, and could not properly be attributed to pre-mortem disease.

However, as neuropathologists began to reign in mental hospitals, the concept of insanity caused by a physical lesion began to hold sway, directing therapeutic emphasis to such factors as rest, diet, room temperature regulation, and physical well-being, and away from sociopsychological factors in the causation of emotional disease. The climate of institutions reflected custodialism; punitive and restrictive practices were directed to control bizarre and aggressive behavior; and accounting systems were designed to house "incurables" at lowest cost and with administrative efficiencies to rival the great businesses growing up in the outside economy. Interest shifted to the niceties of diagnosis, the refinements of legal medicine, and of brain pathology. Quite consistent with this picture was the fact that leadership in American psychiatry passed to John P. Gray, superintendent of the Utica State Hospital in New York, the largest hospital in the land. He introduced the

microscope into American mental hospitals and taught that insanity "is simply a bodily disease in which the mind is disturbed more or less profoundly, because the brain is involved in the sickness either primarily or secondarily. The mind is not, in itself, ever diseased" (Gray, 1885-86).

The optimism, enthusiasm, and psychological sensitivity of moral treatment that dominated administrative philosophy of the first half of the nineteenth century gave way to custodialism, pessimism, warehousing, and overemphasis on neuropathology. Now we are on the road back. In rapid succession, since World War I, *custody* has given way to *therapy,* whilst responsibility for the common man from cradle to grave has replaced rugged individualism and social Darwinism. Following repeated public disclosures of "snake-pit" conditions in our mental institutions, state and federal governments have committed themselves to attempting a final resolution of the problems of neglect and dehumanization. The Freudian enlightenment, which has gained such great influence in all intellectual circles, has made it once again fashionable to discover the details of the inner life of man and to plan therapeutic programs with due consideration for the deeper psychological and experiential forces affecting his adaptation. Administration of mental hospitals since the 1930s has emphasized "eclectic" philosophy, taking advantage of new insights of psychoanalysis, social psychiatry, somatic therapy, and psychopharmacology that have emerged as the terrible plight of the mentally ill has stirred the nation. Many mental hospitals have made

effective affiliations with medical schools, and have developed significant research and training potentialities to enliven and stimulate the therapeutic climate of our institutions.

As therapy replaced custody, the evils of excessive seclusion, wet-sheet packs, overmedication, and physical and mental restraint have disappeared, and the motif of the *therapeutic community,* which mobilizes the total potential of all the hospital citizenry toward progressive improvement of the social-psychological-physical environment, has spurred the imagination of administrators.

This, in turn, has been supplemented by the concept of the *mental-health center,* wherein barriers between hospital and community are broken down and administrators seek to encourage a flow of students, families, volunteers, and community officials across the hospital-community interface. They strive also to set up transitional and extramural facilities, such as outpatient departments, aftercare services, day-care services, halfway houses, cooperative apartments, and specialized community rehabilitation centers for patients now being discharged in increasing numbers.

Since the 1960s, concomitantly with the rise of social medicine, public-health ideology and practice, health insurance, and renewed national resolve to alleviate poverty and attack disease on a grand scale, a new slogan and

concept, the *comprehensive mental-health center,* has come to the fore. Once again, as in the Moral Treatment era, the small hospital is the model; intensive personal concern for the whole individual and his family is the mode, and utilization of every means to restore the troubled mind is the goal. In addition, the superintendent of today assumes responsibility for a *defined geographic area*; he tries to think and plan actively in terms of the mental-health needs of all the citizens of that area, and to explore the community resources that might give formal or informal help to his clients. He thinks in terms of home care, family and network treatment, and the interplay between his hospital and community satellites.

His language is sprinkled with terms such as "risk groups," "preventive intervention," "incidence," "prevalence," "community partnership," "cross-cultural and minority psychiatry" —terms that were heard infrequently before. We are, in effect, in the midst of a virtual social revolution in both mental-health philosophy and practice.

In the foregoing, we have compressed many decades of history into a capsule, in order to show that mental-hospital administration tends to be molded and swayed by changing social and cultural conditions. The superintendent of today is at the pinnacle of this history, able to utilize a great variety of ideas and programs; yet there are expectations that he cannot ignore. For example, if he is a manager of a large state hospital, he will

experience great pressures to reduce the census, rehabilitate his patients into community settings, encourage citizen partnership in many of his endeavors, and promote participation in direct therapeutic care of a spectrum of professionals, paraprofessionals, and nonprofessionals. Moreover, he should be attuned to the voice of minority groups; he should be a strong advocate of equal employment and affirmative action; and he should be an ardent student of legal medicine and of patient rights. His hospital will give much service to alcoholics and to drug-dependent individuals, and he will strive to broaden his therapeutic activities to include proper attention to geriatric cases, adolescents, children, and retarded individuals—these categories having been overlooked or slighted in past allocations of therapeutic resources.

Structure of the Mental Hospital

The chief officer, who has maximum responsibility and authority, is usually the superintendent. In turn, he is accountable to a board of trustees or similar body, usually made up of laymen, that may be either advisory or policy setting. In some states boards of trustees are appointed by the governor; in others, they or their counterparts may be elected by county jurisdiction or, in turn, appointed by elected county officials. The superintendent is also accountable in most states to a commissioner of mental health—who is usually a gubernatorial appointee.

As the chief officer of the hospital, the superintendent appoints subordinates and generally defines their duties. Chief subordinates are usually an assistant superintendent, with authority over nursing service, personnel, the business office, and administrative operations; and a chief medical officer, responsible for all clinical services, research, and training. Direct patient care, therefore, comes under the chief medical officer, whereas all supporting services come under the assistant superintendent.

For the most part, mental-hospital superintendents are physician-psychiatrists, although in recent years there has been a tendency to appoint nonphysicians with experience in administration, or formally trained hospital administrators.

The staff, usually numbering in the hundreds, is divided into departments, each with its own head, spanning the whole complex of areas that have to do with management of a system responsible for the total care of patients—engineering, food service, laundry, personnel, grounds, etc., as well as all professional services such as social work, psychology, nursing, occupational therapy, rehabilitation, pastoral counseling, etc.

Approximately 70 to 80 percent of the average budget of a state hospital goes into personnel, the remainder into administrative overhead. Large institutions have major administrative expenditures related to repairs and

renovations of buildings, heating, clothing, food services, etc., which in recent years have led management experts to favor community care wherever possible over institutionalization, on the theory that the former is not only more humane and therapeutically more effective but also more economical.

Though the mental hospitals in America spend huge sums of money for their patients, the fact is that rarely are these monies sufficient to provide adequate and appropriate care and treatment. The per-diem costs in state-owned institutions rarely approach costs in good private institutions, or in general hospitals with satisfactory psychiatric services. This discrepancy, and the discontent generated in all parties concerned, has been the cause of great distress and strain, a source of innumerable critical investigations and media exposes; and a perennial thorn in the side of legislators and community groups. This "Shame of the States" has been the motivation for much legal action, including *class actions* on behalf of the mentally ill and retarded that now threaten to shake the foundation of institutional care in the United States.

Stresses and Demands on Administration

Superintendents, who in the last analysis set administrative policy, are too often ill prepared for the tasks they face. Not only do they require mastery of a variety of purely supportive or administrative functions, but also, they

must have command of clinical programming so as to give the institution reasonable direction and guidance. They should have more than passing knowledge of the law in order to conform the work of the hospital to legal requirements and to assure patients their legal rights and privileges. In addition to internal operational demands of the institution and his role as its social leader, the superintendent is subject to a variety of extramural demands for public appearances in which he interprets the work of the hospital to people and tries to gain support for its programs and goals.

Administrative officers in public institutions are subjected to numerous strains:

1. The necessity to master new concepts and information related to management functions of a complex therapeutic system, very little of which has been taught to them either in medical school or in subsequent postgraduate training.

2. The high vulnerability of the office due to (a) their responsibility for large sums of public money; (b) the large number of seriously ill patients in their charge; and (c) the generally poor level of care and treatment provided patients in relation to standards of private institutions as well as the general standards for care of the sick acceptable to any informed public.

3. The unusual demands on time, effort, and physical and mental vitality that reduce energy available for self, family, and

friends. In addition to high vitality and robust health, administrators must recuperate quickly from disappointments and losses.

4. Public exposure and criticism are frequently the lot of administrators of public mental hospitals, and this phenomenon is likely to increase in the future.

5. Financial remuneration is not commensurate with private practice or university fulltime employment.

6. Short tenure and uncertain future is the rule. Administrative jobs are subject to the whims of political fortune. A job well done in the professional sense does not necessarily guarantee tenure. As a result, many security-minded professionals shun the responsibility of administrative office.

Rewards of the Administrator

The rewards of the administrative life, nevertheless, are many (Greenblatt, 1972):

> The intellectual challenge and joy of mastering new material, the broadening of one's horizons over a larger sector of one's field, the perspective on large areas of health in relation to its sociopolitical determinants, centrality in the arena of action and decision, the power to do a great deal of good for patients, families, and colleagues, the control of vast resources, the honing of one's judgment, the greater call upon one's personal capacities for performance and achievement.
>
> Beyond these is the opportunity to look after the cherished values of the

> mental health profession—the freedom to treat patients and to teach and to do research in a favorable climate, the elevation of the health and welfare of the citizens to first value in the thinking of the body politic, the opportunity to represent the health of the poor among the multitude of projects clamoring for government attention.

Finally, as Mary P. Follet has pointed out so brilliantly, our success as a civilization depends largely on how well we can solve the functional problems of large organizations in serving the welfare and happiness of the individual.

Basic Decisions of Administration

The hospital is a system dedicated to the goal of serving society through the treatment of mental patients. Within this broad framework, decisions will have to be made that relate both to the philosophy of patient care, the availability of resources, and the administrator's view of management. In the long run administrators tend to fashion their systems in their own image (Greenblatt, 1971). Most of the major decisions depend on instinct and judgment; very often there exists no adequate data base to support any given direction. Part of the difficulty is that both psychiatry and management are relatively young sciences, and in psychiatry, in particular, research on administration is meager.

Regarding the overall allocation of resources, the administrator will have to make a decision as to how to cut the pie for service, training, and research. In the service area he will be faced with judgments on how much

should be done for patients extramurally as opposed to intramurally. He will ponder whether major emphasis should be on acute versus chronic patients; whether the intake of patients should be controlled by the institution or directed by extra hospital forces. Should waiting lists be tolerated? How long should patients be hospitalized? What is the balance between long-term and short-term therapies, between psychotherapy, somatic therapy, social therapy? Should one or a few approaches to treatment be emphasized as opposed to a broad eclectic, try-everything attitude? Is therapy to be practiced only by trained psychiatrists or perhaps opened up to nonpsychiatrists, even nonprofessionals? Further problems that require profound judgment concern choice of a unified philosophy of treatment versus multiple ideologies; centralization of organizational structure versus decentralization into autonomous units; organizational stability as against dynamic change (Greenblatt, 1971).

In the pursuit of organizational change with respect to any specific set of goals, the administrator has to make up his mind what areas to motivate first toward reorganization or reform and how fast changes or progress should be expected; how many areas to activate at any one time; who may he supported as his delegates in creating change; how much effort should be put into working through personnel stresses and strains; and how broad a base of participation in planning and implementing change should he encouraged.

Sayre (1956) has offered four theoretical views of administration. All have to he taken into account with operations of the institution, though one or more may he stressed or favored by a given administrator.

Administration as a technological system wherein cost effectiveness is the primary emphasis. This approach, highly suitable in the business world, where commodities are discrete and easy to identify, is applied with difficulty to the mental hospitals whose commodity is relatively vague—the mental health of clients. Nevertheless, as health costs rise in the future and the public becomes more and more interested in how its money is spent, this aspect of management is sure to become more and more important.

Administration as a system for policy formation and decision making. Where many difficult decisions are to be made, and where participation of staff that will eventually carry out the decisions is required, a broad base of policy formulation and development is desirable. Administrators trained in group dynamics will find this approach highly consonant with their experience.

Administration as a system of responsibility and accountability. More and more the mental hospital finds itself accountable to outside agencies; first, to the mental-health department of the state that has to render reports to executive and legislative branches; second, to its board of trustees; then to the

relatives, friends, and constituents in the community; to the formal citizen organizations promoting mental health; to the professional societies with which the staff is affiliated; to the universities that assist in training and research and confer academic titles upon selected staff; and, finally, to the courts that refer cases for evaluation and consultation.

Further accountability is to a disparate variety of standard-setting or monitoring agencies: the Joint Commission on Accreditation of Hospitals, without whose endorsement the institution cannot maintain its reputation within the family of hospitals serving the nation; the public-safety inspection board of state and/or local level; federal government monitoring regarding Medicare and Medicaid standards; public-health inspection of sanitation, food handling, management of infections and contagious disease. In modern times, the organization is accountable also to the courts which, in one state after another, are imposing standards for adequate and appropriate care and treatment; for proper education of inmates of hospitals and schools for the retarded, and for proper compensation to hospitalized patients for work done that would otherwise require paid employees.

Administration as a social process. In this view the individuals that shape the organization are more important than technology; therefore, participation, cooperation, morale, and consensus are all important. Leadership, then, is the skill necessary to create the proper climate for

individuals and groups to exercise their creativity and to make their maximum contribution.

Miller and Rice (1970) in their studies of task-oriented human systems emphasize discrepancies between sentient systems and organizational tasks as the basis of organizational strain. We have elsewhere stressed the social-process dimension of the organization in attempting to view the administrator's role as one of "social system clinician" (Greenblatt, 1957), comparing this function with that of the "individual clinician" in psychotherapy. In both, identification of areas of anxiety and strain is essential, followed by working through of tensions, release of inner strivings and creative forces, and assumption of greater autonomy and responsibility. Mental-health professionals who assume the task of administrators of mental-health systems will often feel more comfortable with emphasis on social process.

Personality and Style of Administration

It is generally recognized that the *personality* of the administrator in large measure determines administrative *style,* and that both of these factors profoundly affect the fate of the institution under the administrator's command. Administration requires maturity, energy, creativity, humanism, intelligence—a host of virtues that, mixed in proper proportions, spell the

character of the man or woman with leadership qualities. For many years it was taken for granted that the director of a mental-health facility must be a psychiatrist-physician. No doubt, when the functions of the administrator involved intimate knowledge of each patient and personal attention to his medical-psychological needs, as in the Moral Treatment era, that administrator would most properly be a physician. However, with the growth of institutions both in size and complexity, and the necessity for the superintendent to be concerned largely with more administrative details, this requirement has become less crucial. Nowadays, administrators of mental-health facilities may come from a variety of backgrounds where training and experience in institutional management are an important part of their preparation. This has become increasingly true for schools for the mentally retarded, in VA facilities, and in mental-health facilities of those states where psychiatric administrators are difficult to recruit.

Where nonmedical administrators are in charge, administration of all clinical functions is delegated to a chief medical officer or physician-psychiatrist, who is then the chief arbiter of matters affecting the medical and psychiatric well-being of patients. There has been much anxiety in some professional ranks that if final decision making is left in the hands of nonmedical administrators, cost-effectiveness considerations will take precedence over humanitarianism. Whatever the truth of the matter, and perhaps the problem has been exaggerated, the fact is that with sharply rising

costs of medical-psychiatric care and sharply increased expectations of the public for total health insurance, cost-effectiveness factors will be increasingly important in the future.

Personality in part determines the administrator's basic priorities concerning such matters as the welfare and morale of employees, the concern for the image of the hospital vis-a-vis his own image in the community, his philosophy with respect to research and training, his interest in reform and innovation, and so on. Even more basic to the morale of an institution are those intangible qualities which give people a feeling that they are working for a man of strength, integrity, reliability, and warmth. Workers would like to say, "I am pleased to work with such a person." Patients and family feel that with this type of person "someone up there cares for them."

The United Nations technical report links the character of the administrator to the therapeutic effectiveness of the institution, in these words:

> The most important single factor in the efficacy of the treatment given in a mental hospital appears to the committee to be an intangible element which can only be described as its atmosphere. . . . As in the community at large, one of the characteristic aspects of the psychiatric hospital is the type of relationship between people that are to be found within it. The nature of the relationships between the medical director and his staff will be reflected in the relationship between the psychiatric staff and the nurses, and finally in the relationship not only between the nurses and the patients, but between the patients themselves (World Health Organization,

1953, pp. 17-18).

Administrative style seems to flow from the basic character training, particularly early training, of the individual. This area has not been well conceptualized and certainly research is scarce. Sharaf and Kotin (1967), however, have conceptualized one dimension of administrative style that they call "tight-loose." At the tight end, an administrator is concerned with careful definition of role and authority, orderly and hierarchical chain of command, reliance on formal communications, and explicit rules. Loose administrative style favors less explicit delineation of authority and responsibility, tolerance of role ambiguity, informal communications, informal exercise of power, and little reliance on rules and regulations (Sharaf, 1967).

Readers will see at once a relationship between tight-loose administrative style and authoritarianism-equalitarianism in ideology and personality functioning. For example, those who adopt authoritarian attitudes toward politics, family relationships, religion, and ethnic groups are more likely to be interested in structure, precise role delineation, and rigid-role boundaries in organizational functioning (Gilbert, 1957).

Most significant with regard to style is the administrator's ability to adapt flexibly and creatively, means to ends—the use of a variety of approaches, concepts, and styles in solving problems and reaching goals.

Training for Administration

Few specialized training courses exist for psychiatric administrators of mental hospitals. Usually, preparation consists of experience in one or another leadership position in a hospital, such as clinical director, director of education, chief of outpatient department, or head of a day hospital. Apprenticeship to an administrator of known reputation as an assistant superintendent is very useful.

A more formal training in administrative psychiatry and more specifically for the role of administrator of a mental hospital ought to begin with increased awareness and emphasis on the administrative-executive role from the beginning of postgraduate training. Instead of taking for granted the organization in which he is being trained, the graduate should be made aware of the history, goals, methods of operation, personnel relations, business and legal problems of his institution and how and why his postgraduate-education opportunity developed the way it has.

Then, as the postgraduate student or psychiatric resident begins to work with patients, staff, and family, he proceeds with greater awareness that he is part of a *system* and that the treatment he intends to give on behalf of his patients depends on efficient operation of that system. When he becomes a senior resident, ward chief, head of an outpatient department, or clinical director, he is even more involved in, and responsible for, that therapeutic

system.

In the resident years, administrative seminars could enlighten and broaden the resident's grasp of the total scene. In advanced residency years, he could take on a project in the hospital that administration is trying to push forward, under supervision. Increased awareness of the forces in the community that shape the institution and his role in it could be developed by visits to important facilities in his area involved in health care of patients. Knowledge of the roles of welfare, corrections, youth services, and public-health agencies is vital. It is particularly enlightening to talk with important legislators responsible for health legislation and to watch the process of legislative enactment at the state or federal level.

In the case of a resident especially interested in concentrating on administrative science, special courses could be offered through local university auspices in systems management, institutional change, social psychology of groups, health standards, public relations, personnel relations, and legal medicine. Most pertinent to the preparation for the administration responsibility would be field experience, or apprenticeship, to administrators of long experience and known effectiveness. Here it should be noted that our best administrators in the field are not fully utilized as models or teachers. Those who teach often do not teach administration; those who write often write about professional matters other than administration. Many would be

delighted to help younger and less experienced persons with their careers, through regular supervision and guidance similar to that which is offered residents learning psychotherapy.

Finally, the training of the young administrator should include a period of executive responsibility under supervision. A period of training as assistant superintendent to two or more fine superintendents would be advisable. Added to this would be frequent trips to the central office of the state administration of mental health where he learns who is responsible for the various departmental divisions to which he must relate, how they operate, how he and they can work together to the best advantage. In one such department in my experience over twenty units were identifiable, each under a separate chief with special expertise. These included nursing, psychology, social work, occupational therapy, retardation, children's disorders, speech and hearing, legal medicine, drug rehabilitation, alcoholism, geriatrics, volunteering, business administration, farm and grounds, engineering, personnel, liaison with the legislature, public relations, work rehabilitation, hospital inspection, and laundry.

Upon the assumption of the definitive role as director of a mental hospital, the incumbent cannot be left to flounder; he needs supports; opportunities to meet with fellow directors of other institutions to share experiences; refresher courses; visits to other facilities grappling with and

possibly solving problems similar to his own; brief vacations planned for maximum stress relief; periods of role interchange with administrators higher or lower in the chain; and sabbaticals with the opportunity to pursue further education and experience consistent with his intellectual needs.

Too many fine administrators lose their spark as a result of the high chronic strain to which they are subjected. This strain is greater today than at any time in history due to the acceleration of change, the growing complexity of organizations, and the increasing demand for performance by the public. Tenure of administrators in high office may not exceed four to five years on the average. Probably official recognition should be given to this fact by prearranged job changes, sabbaticals, and "recycling" so as to help highly trained individuals to remain in the public service for the longest possible time.

Areas of Concern of the Public Hospital Administrator

The administrator of the state hospital must of necessity gain a mastery in several areas. As mentioned before, it is unlikely that any of these areas have been adequately covered in his previous education. Even when considerable intellectual mastery exists, the administrator will find that *operating mastery* is a different kettle of fish, requiring repeated practical experience in the arena of *action.*

Law and Psychiatry

It will be necessary to have a thorough knowledge of the rights of patients, the rights of personnel, and to know intimately the power of the superintendent and his administrative subordinates as well as the limits of this power. The whole fabric of law, departmental rules and regulations (which when properly processed have the force of laws) and traditional practices governing the exercise of his office must be understood. This is the day of active redress, of quick litigation, and of citizen and legislative monitoring of the actions of their public servants. To get caught outside the law, particularly where it affects patient rights or the proper use of money is to court professional disaster as well as legal punishment. The wise administrator will not only *know* the law to the best of his ability; he will also have legal advice close at hand and avail himself of the legal expertise of departmental officials at a higher level.

Knowing the law regarding patient rights and privileges puts the administrator in a position to "normalize" his patients' hospitalization to the maximum, and to plan further privileges as the behavior of the patient group improves and the trust of staff rises. Patient rights relate not only to admission procedures, social privileges on the ward, testamentary capacity, use of money, maintenance of various licenses but also to their life in the community, temporarily halted by hospitalization. They have landlords who

expect rents and may want to evict them for nonpayment; they may have claims on welfare; they may have dependents temporarily unsupported or business partnerships in jeopardy. Many states have recently restricted the criteria for involuntary hospitalization, mandating periodic reviews and placing the burden of proof on the superintendent to plead before the courts for continued retention of a client.

Laws governing the rights of personnel are equally important. The administrator will quickly learn that one or more labor groups are dedicating their entire efforts to protecting employees' rights and pressing for higher wages, better conditions of work, and more union privileges. Well-worked-out union contracts with superintendents and employee representatives negotiating across the table on a man-to-man basis may set the stage for good employee morale. The administrator will find himself a signator to labor contracts, personally responsible for guaranteeing the rights and privileges contained therein.

Recently, class-action forms of redress have come to the fore, approximately thirty such actions now being before the state and federal courts in various stages of development. These are in three primary areas:

1. Actions relating to proper standards of care and treatment of hospitalized patients of mental institutions or residents of schools for the retarded. In effect, the petitioners ask for

"adequate and appropriate" care and treatment for involuntarily held individuals.

2. Actions related to the right to education of patients in institutions who are missing that opportunity because they are hospitalized.

3. Actions proposing compensation of hospitalized patients for work done for the institution that replaces paid employees.

Present indications are that much progress will be made on behalf of the mentally ill and retarded through the use of the class-action vehicle. Having been denied humane treatment for many decades, appeal now via the courts promises a return to greater "humanism" of the type enjoyed in the Moral Treatment era.

Business Administration

Every hospital director needs a good business manager—-honest, loyal, and dedicated to support the clinical services and to help the director adapt means to ends. This budget officer should see his role as secondary to patient care, never one of controlling or directing patient care or competing with top management. He should be skilled in the utilization of every technical means to make his budget flexible, responsive, and effective in the face of changing demands.

Budget preparation is a skill that the director and his aides must master. Given the general priorities established by the administrator, it is then necessary to obtain inputs from all hospital section heads and many of their subordinates. In other words, budget development is both "top down" and "bottom up."

Budgets may be "line item," with minimum transferability between categories, or they may be "block grants," with much autonomy left to the director, or something in between. The administrator always seeks to obtain maximum flexibility within the allowed rules. Usually, it is also a good idea to spend the budget annually down to the last penny, if possible, because requests for additional allotment are difficult to justify if substantial "surpluses" have been shown in previous years.

The strongest fiscal position that the administrator can enjoy is to have funds coming from a variety of sources—state, university, federal government, and private. The good administrator seeks to diversify, thus becoming less dependent on any one fiscal resource.

Labor Relations

Labor groups are a part of the modern scene. Bargaining, contracts, arbitration are recurrent areas of activity. How the administrator gets along with labor will determine to a large extent employee morale. In his

negotiations with labor he must never bargain away his management rights to run his organization according to the best interests of patients. At the same time, labor is always determined to win ever larger wages and improved conditions. The administrator will have to participate in this progress. Strikes, work slowdowns, sit-ins, sick-ins, and picketing are to be avoided if at all possible. However, the good administrator will give some thought as to what he would do should a strike be called some day, even if illegal. How will he take care of his patients? He will need a plan as precise as his plan for protection against fire, thefts, or natural disasters.

Citizen Involvement

Increasingly, citizens want to know about mental health. They want to understand the functions of their institutions, and to help in the planning and implementation of treatment. At times they may wish to share the responsibilities of the executive role.

Most hospitals involve citizens at several levels:

1. Volunteers who give direct aid to patients. This movement has grown immensely in recent years. Volunteers have become a recognized means of adding to staff effectiveness. Every modern hospital will have a volunteer director and division heads tuned to recruiting, orienting, training, and utilizing volunteers within their general mandate. Patients appreciate

that volunteers provide a link to the community and that their interest is not based on job or remuneration. Student volunteers, in particular, bring to the institution youth, enthusiasm, and optimism—priceless ingredients in any therapeutic climate.

2. The administrator will take active steps to contact schools and community groups, and to establish a bridge to many community activities through volunteers.

3. Citizens serve on mental-health boards as appointed or elected officials, usually advisory, sometimes policy setting, but always significant members of the planning-implementing team. Many have distinguished records of accomplishment in the world and can be of great assistance to the manager in interpreting his institution to the public, identifying sources of support, assisting in relations with the central office and with the legislature.

4. An important set of citizen roles relates to their membership in community associations dedicated to raising the standards of care and treatment of the mentally ill and retarded. They can be most vociferous in recommendations as to how the institution ought to utilize its resources. Some of these groups are very "activistic," seeking their ends through sharp public criticism of the administration, enactment of special laws, or pressure on governors and councils. Their tactics may include destruction of property, threats, and personal vilification.

Problems arise in ghetto communities, or communities with mixed social or socioeconomic groups, as to who in fact represents the people. Those groups which are most activistic may not necessarily represent the majority; nevertheless, they may be intent on getting their way. Some of the most difficult problems facing administrators today are in attempts to provide service to such communities of discontent.

Public Relations

A good deal of effort and attention will have to go into public relations. The administrator's image with his staff and with the outside community are both important.

Instrumentalities for communication with the employee group, not merely their labor representatives, should be developed—newsletters, social gatherings, group activities of various sorts—through which the feelings and problems of employees may be identified and, at least to an extent, expressed. The way the administrator conducts himself, and his reputation for courtesy, caring, and helping his staff will play a great role in morale and in creating a proper therapeutic climate.

Public relations directed toward the community should be on a planned and continuing basis. Many different sectors of the community will have to be dealt with—families, interest groups, university affiliates, legislators, the

press, and other media. All this will be directed toward interpreting the work and goals of the hospital, fostering a climate of acceptance by the public of mental illness and mental patients, and encouraging contributions of personal service, material, and funds , on behalf of the mentally ill.

Special Problems Facing the State Mental Hospital in the Future

Although it is risky to predict the future, particularly in a field so subject to change as health services, we may identify current trends that, for some time at least, may continue to be manifest.

1. Decreasing the number of patients in mental hospitals is still going on in most of the state hospitals in the nation. Administrators, in fact, have shown pride in their ability to move patients into the community. Concomitant with this trend has been the movement of staff into hospital-generated community services such as satellite clinics, halfway houses, cooperative apartments, and work-rehabilitation centers.

2. Decentralization of hospitals into semi-autonomous units, each with its own therapeutic team responsible for a designated "catchment" area will probably be explored further. Patients from a given geographic area are admitted, treated, discharged, and followed up by the same team. Differentiation between acute and chronic patients is reduced. Population reduction is accelerated, and community liaison via bridging activities is increased.

3. Planning of services to the catchment area, jointly with community facilities that have sprung up independent of the hospital, and together with citizen representatives of the geographic area, will certainly be increased in the future.

4. There will be greater utilization of mobile home-treatment services, family therapy, network therapy; and greater dependence upon collaboration with both formal and informal care givers in the community.

5. There will be greater utilization of volunteers and paraprofessionals, both in the hospitals and in the community.

6. As the hospital population decreases, the trend toward admission of clinically more severe cases will continue with increasing representation of drug dependent, alcoholic, geriatric, brain-damaged and retarded individuals.

7. There will be greater efforts to provide total services for disturbed and delinquent adolescents and mentally ill children through a variety of newly developed modalities—such as day care, home care, nurseries, and schools.

8. The treatment of the emotionally disturbed offender will receive greater emphasis in the future. Mental-health administrators will collaborate with correctional administrators in ascertaining the common ground for their joint efforts.

9. There will be greater emphasis on work rehabilitation and the value of compensated-sheltered workshop employment as

well as community-employment training in the treatment of mentally ill patients.

10. The phase out, or closing, of some state hospitals is likely to continue.

11. Conversion, in whole or in part, of some state hospitals serving the mentally ill to schools for the retarded, or training centers for juvenile delinquents and adult offenders may be expected.

12. Collaboration with public-health agencies toward developing total-health, rather than simply mental-health, services to sick individuals will increase.

13. Upgrading of care and treatment in state mental hospitals to more humanistic and acceptable levels will occur as the public, aided by the courts, becomes increasingly determined to provide adequate and appropriate treatment to all indigent ill persons.

14. Increasing experimentation by state government with nonmedical cabinet-level administration of mental-health systems by executives lacking direct service experience will occur concomitantly with the rising need for greater efficiency and economy in management of large governmental organizations.

15. There will be increased monitoring of the functions of mental hospitals both by state and federal government officials and by interested citizens from the private sector.

Bibliography

Bockoven, J. S. *Moral Treatment in Community Mental Health*. New York: Springer, 1972.

Dickens, C. *American Notes for General Circulation*, Vol. 1, 3rd ed. London: Chapman & Hall, 1842.

Gilbert, D. C. and D. J. Levinson. "Performance, Ideology, and Personality in Mental Hospitals Aides," in M. Greenblatt, D. J. Levinson and R. H. Williams, eds., *The Patient and the Mental Hospital*, pp. 197-208. New York: Free Press, 1957.

Gray, J. P. "Insanity; Its Frequency, and Some of Its Preventable Causes," *Am. J. Insanity*, 42 (1885-1886), 1-45.

Greenblatt, M. "The Psychiatrist as Social System Clinician," in M. Greenblatt, D. J. Levinson, and R. H. Williams, eds., *The Patient and the Mental Hospital*, pp. 317-323. New York: Free Press, 1957.

----. "The Elongated Shadow," *Compr. Psychiatry*, 12 (1971), 293-301.

----. "Administrative Psychiatry, *Am. J. Psychiatry*, 129 (1972), 384-385.

Greenblatt, M., M. Sharaf, and E. Stone. *Dynamics of Institutional Change*. Pittsburgh: University of Pittsburgh Press, 1971.

Greenblatt, M., R. H. York, and E. L. Brown. *From Custodial to Therapeutic Patient Care in Mental Hospitals,* pp. 408-409. New York: Russell Sage Found., 1955.

Miller, E. J. and A. K. Rice. *Systems of Organization: The Control of Task and Sentient Boundaries*. New York: Social Service Paperbacks, 1970.

Pinel, P. A *Treatise on Insanity*, translated by D. D. Davis, p. 5. London: Cadell & Davies, 1806.

Ray, I. "Ideal Characters of the Officers of a Hospital for the Insane," *Am. J. Insan*., 30 (1873), 67.

Sayre, W. S. "Principles of Administration," *Hospitals*, 30 (1956), 34-35.

Sharaf, M. and J. Kotin. "Management Succession and Administrative Style," *Psychiatry*, 30 (1967), 237-248.

Sumner, W. G. *Essays of William Graham Sumner*, Vol. 2, p. 107. New Haven: Yale University Press, 1934.

World Health Organization. *Expert Committee on Mental Health*, 3rd Rep., Techn. Rep. Ser. no. 73. Geneva: WHO, 1953.