ABSTRACT
                The theoretical and practical importance of being
responsive to the personal needs of the mental health worker is
discussed. It is hypothesized that for mental health workers to
function at optimal levels of effectiveness both within an agency and
in delivering service to clients within an agency context their own
needs for recognition, support, and enjoyment must be attended to. The
view of the comprehensive community mental health center (CCMHC) as
an interdependent system where clientele, service staff, and
administration are continually affecting and being affected by one
another is presented. Social system, family interaction, and
individual personality theory are briefly discussed so as to provide
a framework and rationale for this view. The authors' experiences at
two mental health agencies illustrative of good and bad mental health
practices with regard to staff serve to crystallize relevant issues.
In conclusion, specific proposals to provide for the needs of mental
health staff and the improvement of agency functioning are presented.
(Author)

The Forgotten Staff: Who Cares for the Care Givers?

by

Allan Scholom   and   Baron Perlman
Illinois Institute of Technology   University of Wisconsin-Oshkosh

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In creating the comprehensive community mental health center to assume responsibility for service delivery in the United States (4, 5) a major legislative goal was to establish agencies that were geographically closer and more personally responsive to the client/consumers within a given community. This was a reflection of the trend of the Sixties which witnessed a decentralization of numerous programs, organizations, and institutions as evidenced by more local (community) control of schools, governmental organizations and mental health agencies. The movement toward community involvement was a reaction against a growing sense of powerlessness, depersonalization, and bureaucratization among the populace as control of one's life moved increasingly away (geographically, politically, and inter-personally) from one's sphere of influence. From Future Shock to the Sunday supplements, this social upheaval has been repeatedly documented.

Within this context a major aim of the comprehensive community mental health center (CCMHC) was to be more accessible, available, and affordable to consumer needs than other existing and/or alternative sources of mental health care (hospitals, child-guidance clinics, private practitioners). While one might agree that some progress in this domain has been made, it is interesting to note that there was no legislative concern for, nor programmatic investment in, the care givers of mental health service who continued to suffer the slings and arrows of alienation (poor morale). It is our belief that the quality of mental health service delivery is limited by a lack of the system's responsiveness to the providers of such service.

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By the "system" we mean legislative financing and philosophy, administrative priorities and practices, and the attitudes and behavior of front line staff. Simply put, mental health staff, especially direct service staff, are often neglected. In the long run by not taking into account the "mental health" needs of staff, we hypothesize such neglect results in low morale, which can inhibit staff productivity and involvement. This in the long run could decrease the quality of service to the citizen consumer.

Our sense is that the neglect of mental health staff is widespread. While we believe our experiences (and many others with whom we have discussed the issues and problems presented herein) are not untypical of the state of affairs present in many mental health agencies we do not as yet have "hard" data to support our discussion (we are now collecting data aimed at documenting this). Thus we view the present endeavor as an orientation to the kinds of problems that exist in at least some CCMHC's and which might be present more generally in others.

The basis for this orientation goes beyond our own experiences with and thoughts about staff morale. Industrial and organizational research (see 7, 11, and 12 for extended discussions) over the past 25 years has focused extensively on job satisfaction, productivity and the relationship between these issues. While findings are varied and complex there does not appear to be a direct consistantly demonstrated relationship between morale and productivity. However, research does indicate a clear relationship between the internal functioning (i.e., task and role definition, group cohesion, channels of communication, etc.) of an organization and employed satisfaction. Thus, good staff morale is predictive of effective internal agency functioning. On this basis alone the importance of attention being directed to the problem of staff morale at CCMHC's is clear. Should there prove to be a relationship between staff

satisfaction and quality of service delivery the issue of morale takes on even greater significance.

What we shall focus upon herein is: (1) a discussion of the theoretical importance of attending to staff needs; (2) descriptions of agencies demonstrating "good" and "bad" mental health practices for staff and their consequences for service delivery; and (3) suggestions for improving staff morale and agency functioning.

A final purpose is to provide an overview of what we perceive to be an important problem that will lead to evaluation and intervention programs aimed at: (1) assessing the morale of the staff at mental health agencies and delineating more empirically the factors that determine good morale; (2) determining the relationship between morale and internal agency functioning as well as the quality of service delivery; and (3) implementation geared toward improving staff morale and determining the effect of this on agency functioning and service delivery.

What do we mean when we say that staff needs are neglected, and why should this be important? We shall first focus on the latter.

Mental Health Staff: Why Bother to Remember?

Our thesis is this: When the needs of any significant aspect of a system are not satisfied that system will not function maximally. If a community is ridden with political corruption or physical deterioration, involvement of local citizens with each other and in community affairs will be lessened, and the quality of life in that community may suffer. When even one member in a family is isolated or scapegoated this is an indication that the entire family is troubled. If an individual is continually "repressing" his or her aggressive feelings, or any sugnificant aspect of their personality, such needs will go unsatisfied and thereby limit the person's overall functioning. Similarly, if we conceive of a mental health

center, itself, as a system which can be conceptualized either as an
interplay of individuals; as a family, or as a community, then we must
accept the importance of taking the needs of all aspects of that system
into account, if the system is to function up to its potential.

As Warren (13) points out, a social system must be aware of and
devote time to both its external and internal functions. A mental health
agency clearly focuses most of its energy on its external, service ori-
ented tasks. Such service (psychotherapy, consultation, etc.) to individual
consumers and other agencies within the community define the external func-
tions of the mental health agency. But what about a system's internal func-
tioning? As Warren (13) stresses, in order to adequately perform such goal
directed external functions, the internal requirements of a system must be
maintained. What then are the internal functions of a CCMHC?

Perhaps the primary internal function in any organization and the major focus of our discussion here concerns the issue of. <u>staff morale and job satisfaction</u>. We will discuss this issue from these different conceptual frameworks: Social system theory, family interaction theory, and individual personality theory; so as to stress the theoretical validity and importance of staff satisfaction. Then our discussion will turn to our own experiences in mental health settings to illustrate more pragmatically the importance of staff needs in the functioning of an agency.

Historically, there has been much concern with interaction both among and within <u>social systems</u> (6, 8, 9).

For example, Homans (6) differentiates a system in terms of <u>task</u> functions and maintenance functions which correspond closely with Warren's (13) external and internal functions. Maintenance functions involve the influence of the social and work relationships of an agency's staff upon their effectiveness in performing their tasks. Simply put, the more positive feelings they develop toward each other and the agency, the greater will be their ability to do their job.

What is most clearly and consensually recognized is that the internal mechanisms of a system must not be neglected by the system's members.

Often times when viewing an organization from a system theory viewpoint the discussion focuses on the many facets of task function, i.e., the relationship of system to system, making a profit, or providing a service. Herein we choose to focus upon maintenance (internal) functions. When viewing a mental health agency as a social system we must, therefore, consider the extent to which maintenance functions are being neglected. Who pays attention to staff needs and feelings? We do not believe that staff can meet task functions maximally without time and support to "keep their own house in order".

Within the framework of family interaction theory (1, 3, 10) the family is usually conceptualized as an inter-dependent system. Family theory, more directly than social system theory, emphasizes a balance or homeostasis in underscoring the importance of every part (individual) of that system in contributing to its proper maintenance. For example, Ackerman (2) points out how the "scapegoat" serves the function of being the repository of all the family's discontent. But without that scapegoat the family would be forced to find another outlet for its frustrations and disatisfactions. If one were to intervene in this system, one would try to redistribute the sources of discontent and conflict more equitably and appropriately amongst all the family members. In other words, the focus would be on how the system collaborates in setting up an unhealthy environment rather than on a particular individual. Once again the emphasis is on the interactionist nature of the system in which everyone affects and is affected by everyone else.

To use another family analogy, let us consider a "typical" family where parents are expected to provide children with emotional support. Similarly in an agency, the therapist provides this to a client. In a family, when mom

and dad give only to their children and not to each other, or more generally have some difficulties in their own relationship, dissatisfactions and frustrations often arise. Analogously, in a mental health center might not the same be the case? The staff's constant giving to clients and inability to "give" or to at least resolve interpersonal difficulties may result in less than optimal service delivery.

It is also more than coincidental to note that as in a less than "healthy" family, members of a staff of a CCMHC rarely spend enough time doing some of the things which might propogate a healthy system, i.e., talking with each other informally, being supportive of one another, consulting amongst themselves, working through interpersonal dissatisfactions, and the like. A mental health agency staff can and should in some sense be seen as a family unit. Such a view again highlights the importance of meeting staff needs. We all, as mental health workers, know the consequences within a family when individual members feel left out and unattended to. This is precisely what we see to be the case based on our experiences with several mental health agencies. Staff are often neglected and unattended to themselves.

A third and final way of looking at mental health agencies is the more traditional individual perspective. Starting with Freud, most personality theorists while acknowledging the influences of the family and to a lesser extent the social system, tend to build their theoretical conceptions around the individual himself; witness the Diagnostic and Statistical Manual of the American Psychiatric Association. Further, within most theoretical systems from psychoanalytic to behavioral there is some agreement as to the importance of certain basic "truths" in living. All theories concur that to be healthily alive means to be aware of an act on as many of one's feelings as possible

and to have these actions produce positive consequences.. In other words, to take a gestalt point of view, mental health can be generally conceived of as the expression and gratification to some degree, of all, or most of, the various facets and needs of an individual's personality or "self".

Many mental health centers place little emphasis upon and in some cases virtually ignore one aspect of their "self", i.e., their staff. And to the extent that any part of this "self" (family, mental health center, or community) system, however one chooses to think of it, is neglected, the entire "self" suffers. What, then, are the needs of a mental health staff and how are they being neglected? It is to this question that we now turn.

Staff Needs: Once Remembered and Once Forgotten

What are the needs of a staff at a CCMHC? There is nothing mysterious about the answer to this question. Like anybody on any job, mental health staff need <u>recognition</u>, <u>support</u>, and <u>enjoyment</u>. By recognition we mean economic remuneration as well as interpersonal feedback from supervisors and other staff for a job "well done". By support we are talking about in-service training, staff development seminars, and the opportunity to engage in co-therapy. Under enjoyment we would include (beyond satisfaction from working with clients) the opportunity to socialize with other staff, and the freedom to pursue personal interests within the job setting.

We believe these job needs are of particular importance in a mental health setting because of the nature of the work itself. We have found that the demand of a high caseload, long hours, and an often chaotic work situation is many times the norm for a mental health professional. Most professionals would agree that doing psychotherapy is both a demanding and gratifying activity. Staff need

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the time and the milieu in which to ventilate their frustrations as well as share their joys. We have found that there is a consensus among most mental health professionals that to be effective with one's clients one must be satisfied to some degree with overall job conditions. This attitude is consistent with the rationales previously illustrated and stated; that social system, family, and individual perspectives are relevant in understanding the internal functioning of a mental health agency.

The delineation of three major areas of staff needs (recognition, support, and enjoyment) comes from our experiences with both a university based psychological clinic and a community based comprehensive mental health center. We would like to illustrate how these needs are dealt with differently in the two centers and the consequences of this for both staff and client. Briefly, the psychological clinic is located in the department of psychology of a large mega-versity. Its purpose is to train clinical psychology graduate students and when service load becomes heavy referrals are made to other agencies rather than over-extend its therapists and staff. Its major focus is long term psychotherapy, often more than one year, for families and individuals in a variety of treatment modalities. Each case receives close scrutiny in all phases including intake, therapeutic work, and termination. From a staff perspective communication between therapists is encouraged formally through group supervision, seminars, case presentations, as well as informally in the lounge and staff offices. A basic characteristic of the agency is an understanding that its focus is on serving both clients and staff. For example, the sharing of difficult administrative and therapeutic decisions by staff collectively has beneficial effects for both care giver and receiver.

Staff feel less isolation, more support and increased satisfaction as a result of doing a better job, while clients benefit from increased input into issues affecting their treatment in a direct fashion and indirectly from receiving service from a professional whose own needs are being attended to.

One case stands out as an illustration of the above issues. This was a case involving several therapists and two families seen over a period of four years. The original clients, a family consisting of a mother and three young children were seen in various treatment modalities (child psychotherapy, family therapy, and finally individual therapy for the mother) by two therapists conjointly over a two year period. Toward the end of individual treatment the mother became involved with and eventually married a man who retained custody of his children following his recent divorce. He was seen at the clinic by a third therapist in both short term individual therapy and then, with the mother, as a couple. Following some time the couple, then married, were seen by two other therapists in a couples group. The clients continue to maintain contact with the agency via an occasional "booster shot" interview. This was a case involving many major crises and life changes, both for the adults and children including divorce, remarriage, and the construction of a new family, as well as other more longstanding intrapsychic and interpersonal issues. The main point is that a lot of therapists were involved with a lot of people in a very interconnected way, over a long period of time.

What were the features unique to the clinic that maintained this thera-peutic contact? The clinic staff was able to help these people by providing continuity and flexibility of treatment. These extended and varied involve-ments came about because staff, moreso than in the community agency to be discussed below, had the opportunity to: (1) allow the clients to proceed

at their own pace without pressures to terminate because of heavy intake, or caseload responsibilities; (2) discuss at great length among themselves the crucial issues involved in treatment including client dynamics and intervention strategies such as the transfer to new therapists and the inclusion of a new family; and (3) receive support during the difficult phases of treatment by way of training to provide intervention in the several modalities necessary to effectively manage the case. For example, the mother who had initially resisted any direct involvement in treatment which necessitated individual therapy for her children, gradually developed enough trust to include herself in family therapy.

We view the above case as an illustration of the kind of quality of service delivery that can occur if an agency attends to the needs of its staff. In contrast, let us now look at the more "typical" state of affairs in mental health: service oriented community agencies. While we understand that not all CCMHCs are beset with problems on the same scale as the one to be discussed we believe that it demonstrates the kinds of difficulties that afflict many CCMHC's.

In comparison to the aforementioned clinic our local CCMHC serves a catchment area of 200,000. High community demands for service are increasing with resultant pressure on already overburdened professional staff. A typical worker might have as many as 80 active cases on an outpatient load. They are required to interview three new intakes per week and make dispositions for them. In addition, paperwork and meetings result in even more demands upon staff. Our perception is that staff at this agency find themselves now at a point of low morale due not only to excessive work requirements but the lack of recognition, support, and enjoyment. We would like to add, though, that heavy work loads and busy schedules do not in themselves lead necessarily to low staff morale although they may be a contributing factor.

While these pressures can be alleviated by additional economic resources we would still contend that would only be half the answer.

The other half concerns the more interpersonal aspects of the job. To be specific, besides low economic compensation of staff, we found the following areas of neglect: (1) staff seemed to receive minimal positive feedback for the amount of work accomplished. We believe this is in part a reflection of the fact that supervisors and other staff do not have the time to even know what others are doing; (2) a corrolary to this is that the staff are often unable to discuss difficult cases or issues amongst themselves; (3) there seemed to be little time or emphasis on staff pursuing personal interests or developing themselves professionally. Even a weekly outpatient staff meeting was absent in this agency.

Woven within these interpersonal issues are obvious economic components that if changed could improve the situation. However, it is our observation that this would only be a first step and that internal maintenance functions would not automatically be taken care of because there was more money. Administrators and staff would have to make conscious decisions to actively encourage and build in the recognition, support, and enjoyment we consider so important. Even well paid staff with free time can be disgruntled, isolated and unhappy. Witness the old television program "The Millionaire", which dramatizes this dilemma well. A million dollars was given to a new person each week with the idea of seeing how that affected their lives. The result was frequently less than the good life, and always the road was beset with problems.

In closing our discussion of the forgotten staff we would like to focus on an episode which involved neither economics nor service (client) oriented issues. We view this as a clear example of an interpersonal problem which if left unattended to could have led to a considerable degree of tension and dissatisfaction within the agency in question (or in any organization with a comparable set of circumstances), which might have had a deleterious effect on the quality of service delivery.

In the psychological clinic referred to previously a change of directors recently took place. One result of this was that members were experiencing many of the symptoms a child might feel as a result of the divorce of his parents and subsequent remarriage, i.e., hostility, withdrawal, and a sense of loss. To have ignored staff reactions to this event or not appropriately focused upon them would have been extremely unresponsive to staff needs, and may have resulted in much staff alienation and low morale. What actually took place is that at meetings and through informal contacts feeling about this change of leadership were expressed and discussed. The crucial point is that this change was considered significant and time was found to deal with the complex sets of feelings different staff members had. This is not an isolated event in mental health agencies or in any family, organization, or community. It is good mental health to deal with such major changes. If this is not done not only are we neglecting our own feelings but serving as poor models for our clients and all those who come into contact with us.

Some Suggestions to Remember the Staff By

In the preceding discussion we have presented both a theoretical rationale and our experiences and observations from actual work in mental health in order to convey a sense of priority as to the importance of taking into

account the needs and feelings of staff in a mental health work milieu. We
would now like to outline some suggestions, we believe will be and in many
cases have found to be, useful in effecting this philosophy.

1. Encouraging/mandating/building in/inservice training, staff development
   seminars, outside professional contacts, and so on so that staff needs
   for professional development are responded to. Professional staff,
   regardless of the quality of their work, often experience a sense of
   stagnation. New ideas and other stimulation and input are needed to
   maintain their quality of service delivery as well as to communicate
   to staff that their own development is important to the agency.

2. Encouraging the use of co-therapy. We have found this not only to be
   particularly effective with groups and families in a therapeutic sense,
   but it also allows therapists to model techniques and share ideas and
   perceptions in a way which is only possible when one is actually seeing
   a client while with another colleague during this process. Most mental
   health workers find co-therapy to be an enjoyable and supportive process.

3. Having someone on a mental health staff who fulfills the role of super-
   visor and consultant to other staff members. Time should be made available
   to staff on an as need and/or regular basis for this consultation. Such
   an opportunity acknowledges overtly for staff that many cases are difficult
   to deal with, that supervision is a continual ongoing process, and that
   time exists for these problems to be dealt with.

4. Providing staff with the opportunity to involve themselves in some other
   aspect of the agency. For instance, an outpatient therapist may wish to
   gain some experience working on an emergency service doing crisis inter-
   vention type activities.

He or she should be allowed time during the course of each week, if desired, to spend on that unit. Even two or three hours a week engaged in a different task in a separate location in an agency can give a mental health worker an opportunity to break the set (rut) we can easily get into. Such experiences not only can be personally stimulating and enriching to the staff member but can also provide him with fresh ways of looking at his job, thus increasing his level of skill.

5. Allowing staff members time in the course of every day to meet informally in a lounge or some other non-working place which is clearly their own. We know of one agency where such a lounge is called the "family room" and is used by staff as a sanctuary away from the pressures of their job. Such a place allows staff the freedom to talk about anything from the weather to their cases. The availability of such a haven and the time to use it gives staff above all the "room" to do what they want.

6. Approving of mental health time off for staff. This may be accomplished through the use of sick days (even if one is not ill), or half-days clearly designated as mental health breaks. The half-day concept is particularly important. Often one comes into work and is just not "with it" in the morning and it would best serve both client and staff member if mechanisms existed for the staff to take a half-day off. In most work situations people deal with fatigue, boredom, and pressure by occasionally not going to work. Mental health staff need to remember that on occasion their clients can live without them, that the agency will not fall apart and that they, like anyone else can take a "mental health day" off from work.

7. Providing secretarial staff the opportunity to have input into agency
policy and to attend staff development functions if they wish. While
this is not novel the point is that secretarial staff must be seen as an
important part of the agency and as such must be taken into account.
A fringe benefit of this is that some nonprofessional staff can be trained
to perform some of the functions usually assigned to professionals. This
has the dual positive effect of decreasing the work load of the profes-
sional staff while giving the nonprofessional an increased sense of
importance. We know of one CCMHC where initial intake is successfully
handled by a nonprofessional.

8. Addressing the issue of staff meetings. We know that agencies can go to
extremes regarding the length, variety, and number of meetings held.
However, meetings can be useful both to bring staff into contact and to
provide an arena to ventilate dissatisfactions as well as "good stuff".
The business of frequency, intensity, and duration of meetings is an
important issue which needs to be resolved under the guiding principle of
"what best serves the needs of both clients and staff".

9. Lastly, providing at a multi-agency or even state level an individual
designated to consult with administration and staff about maintenance
(internal) function issues. Such an individual could assume an important
role in a system through his or her ability to provide objective feedback to
agencies and hopefully the power to push for necessary changes.

A Concluding Reminder

Mental health work is an endeavor immersed in paradox. We strive to help
a person change and yet we know we must first accept him as he is.

Similarly, the client seeks to change and yet he must come to accept him-
self as perhaps the most important step in the process of changing. We
try to help others live their lives more happily and yet often neglect our
own backyards. In keeping with the motto that says something to the effect
that things begin at home, it is imperative that we concern ourselves not
only with the needs of our clients but ourselves as well. We believe the
notion of the mental health worker as an all giving benevolent person to
be an archaic one that can be ultimately destructive to both client and staff;
sainthood is a fine thing - for Saints.

We choose to be in this field and consequently accept its frustrations
and satisfactions, but all too often give and feed without being given to
or fed ourselves. In this way we often fail ourselves and our clients by
not asking for what we need and want. For reasons we individually know all
too well it is usually easier for us to be this way. We hope that others
(administrators, politicians) will recognize and attend to our concerns and
yet we also know that for us to be assertive is good mental health. Thus
it is our belief that the system's lack of responsiveness to staff needs is
the responsibility of both staff and administration to change - it takes two
to tango. If the feeling tone and orientation we have tried to communicate
in our acknowledgement of the forgotten staff serve even as an occasional
reminder that staff should never be neglected then our own needs will have
been more than gratified.

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