DOCUMENT RESUME

ED 241 833 CG 017 310

AUTHOR Goplerud, Eric N.; Walfish, Steven
TITLE Weathering the Cuts: A Delphi Survey on Surviving Cutbacks in Community Mental Health.
PUB DATE Aug 83
NOTE 44p.; Paper presented at the Annual Convention of the American Psychological Association (91st, Anaheim, CA, August 26-30, 1983).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Community Programs; Delphi Technique; *Financial Problems; *Institutional Administration; Long Range Planning; *Mental Health Programs; Personnel Management; *Policy Formation; *Resource Allocation; Staff Utilization

ABSTRACT

Although the major locus of mental health care in the United States is in community agencies, funding cutbacks threaten the services those agencies provide. To assist human service managers in developing guidelines and concrete action strategies for dealing with financial problems, 106 mental health professionals (e.g., agency directors, technical experts, government officials) with knowledge of community mental health center (CMHC) cutback management issues participated in a delphi process to identify action strategies. In the first round, panel members described 77 actions which might be conceptualized to weather cutbacks. In the second round, those action strategies were rated on four dimensions (importance, desirability, feasibility, and validity), resulting in a rank ordering of the strategies. On the third round, panelists identified and ranked 15 strategies which they felt were most critical for weathering cutbacks. An analysis of the results showed a substantial consensus between the second and third round rankings. The 15 most important action strategies fell into internal organizational management and external environmental management categories. Internal organizational management strategies included development and maintenance of management information systems, priority setting in the areas of services and personnel, and improvement in business practices. External environmental management strategies included development of agency board coalitions, fund raising capacity, and client screening. (Listings of the top 15 strategies and the overall 77 strategies are appended.) (BL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

Weathering the Cuts: A Delphi Survey on Surviving Cutbacks in Community Mental Health[1]

Eric N. Goplerud[2]
George Mason University

Steven Walfish[3]
Northside Community Mental Health Center

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
X Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Eric N. Goplerud
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Running Head: Cutbacks

CG 017310

Paper presented at the Annual Convention of the American Psychological Association, Anaheim, CA, August 26-30, 1983.

Footnotes

1. The authors gratefully acknowledge the help provided by Anthony Broskowski throughout the research and writing of this article. This research was funded in part by a grant from the Council of Management of the National Council of Community Mental Health Centers and by the Northside Community Mental Health Center, Tampa, Florida. The authors also wish to express their appreciation to the Delphi panelists, without whose insight, this research could never have been done. Special thanks are extended to Marie Apsey and Gwen Saylor for their efforts throughout different phases of this project and to Murray Levine, Dick Woy and Terry Goplerud for their comments on an earlier draft of this article.
2. Requests for reprints should be sent to Eric Goplerud, Department of Psychology, George Mason University, 4400 University Drive, Fairfax, Virginia 22030.
3. During the time period in which this study was conducted the second author was supported through a National Research Service Award from the National Institute of Mental Health (MH 08639-01).
4. Copies of the ratings on the four dimensions of Round Two, and the descriptive statements for the four dimensions are available from the first author.

Abstract

With recent cutbacks in community mental health funding the development of practical and viable survival strategies for local agencies is of paramount interest. A Delphi study was conducted in which a panel of agency directors, technical experts and state, county and federal officials with responsibilities for oversight of community mental health services generated 77 separate action strategies. Discussion is focused upon the consensus of the 15 most important strategies that local agencies should consider to improve their ability to survive and even thrive during times of competition for scarce service funds.

Weathering the Cuts: A Delphi Survey on Surviving Cutbacks in Community Mental Health

Presently the major locus of mental health care in the United States is a network of 703 community mental health centers (CMHCs). Since the landmark Community Mental Health Centers Act was passed in 1963 more than two billion dollars of Federal assistance has been channeled into community-based mental health, alcohol and drug abuse services. Those funds, combined with funds from state and local governments, dramatically expanded the availability of public mental health care over the last two decades. Between 1968 and 1978 the number of persons treated annually in CMHCs rose by almost 800%, from 271,000 to 2.1 million (NIMH, 1981). Along with this rapid increase in service, the number of psychologists employed by CMHCs also rose, from just over 1,000 in 1968 to 6,565 Ph.D. and M.A. psychologists in 1979. Community mental health centers are particularly important as training sites and employers of recently graduated psychologists. A recent APA survey found that 15% of recent doctoral recipients in psychology were employed in such settings (Stapp, Fulcher, Nelson, Pallak, & Wicherski, 1981).

With the Omnibus Budget Reconcilliation Act of 1981 the federal involvement in community mental health services changed. Federal funds for CMHCs were cut by 37% from $685 million in fiscal 1981 to $432 million in both fiscal 1982 and 1983. Combining CMHC funds with funds of other previously categorical health and human services into block grants to states, the Omnibus Act shifted responsibility for

fiscal and programmatic oversight of community mental health, alcohol and drug abuse services to the states. The regional offices of NIMH, which has provided oversight and technical assistance to CMHCs were eliminated, and over half of the extramural staff of NIMH were cut (Cunningham, 1982). Human services throughout the country have been faced with sharp cutbacks in funds. Further, service mandates have changed as state and local funding agencies assert their priorities.

The effects of these changes on the services provided by individual agencies may be profound. Studies of CMHCs which had completed the eight year basic period of federal assistance found that, although most CMHCs survive, "within a year after defunding, the CMHC ideology is in jeopardy among graduate centers" (Naierman, Haskins, & Robinson, 1978, p. 88). Specifically, agencies begin compromising prevention, early intervention, and case finding programs: reducing consultation and education, eliminating satellite clinics and outreach programs, and shifting away from outpatient towards more profitable, insurance-reimbursed inpatient programs (Naierman et al., 1978). In most cases, local sources of revenues were insufficient to maintain the comprehensive range of services which had been provided while the agency was receiving federal assistance, and services which could not pay for themselves were eliminated. With the reductions in federal funding signaled by the Omnibus Act, and the shift in oversight responsibility to the states, many agencies are forced to confront the unpleasant task of managing cuts in funds and services.

What can be done? NIMH sponsored a working conference in 1980

ERIC

to develop strategies for promoting CMHC survival following defunding (Woy & Mazade, 1982). The conferees generated 114 recommendations for dealing with cutbacks: 110 focused on changes that government, especially the federal government, and insurance carriers could make. Only four addressed local agencies. With the passage of the Omnibus Act a year after the conference, it has become painfully clear that the brunt of the responsibility for guiding CMHCs and other human service organizations during the cuts will fall on the administrators and boards of individual agencies, not on governments. But, again, what can be done?

Sarason (1972) suggests that most human service systems operate under the "myth of unlimited resources." This myth implies that there will always be enough resources in terms of personnel and funding to render the quantity and quality of services that are needed by our society. He argues that the denial of the limitation of resources must be confronted because reality will ensure that they will be confronted. Many CMHC managers and boards are not prepared by training or experience to deal with defunding. Naierman et al. (1978) concluded: "centers are managed by directors who, for the most part, are not successful in maximizing the potential of CMHCs to perpetuate community-based mental health services. It is clear that the return on [the Federal] investment would be far greater should properly trained individuals mind the centers" (Naierman et al., 1978). Agency directors and boards who have sought formal financial and program management training have not been systematically prepared to deal with the special problems of contracting organizations. A review of Saul

Feldman's (1980) seminal textbook on administration of mental health services illustrates this problem. In Feldman's text twelve basic management functions are reviewed by specialists in each area. Guidelines and practical suggestions abound. Yet, for example, in an excellent overview of planned change, retrenchment is mentioned once. In a chapter on program planning, there are no specific guidelines about how a manager should handle cutbacks. The chapter addressing program evaluation focuses on the barriers and possible uses of evaluation, but does not mention the now critical problem of whether there will continue to be any evaluation conducted at all in CMHCs now that it is no longer required by federal regulations. While the Feldman text provides a good review of general management issues, an agency manager facing cuts would find little practical guidance for how to deal with his immediate or long term problems. Without some specific assistance and training, it is very likely that the pattern Naierman et al. reported among CMHCs after termination of federal funding, i.e., reductions in services, especially prevention and outreach, losses of qualified staff, and chronic financial instability, will be replicated in hundreds of settings across the country.

Broskowski, O'Brien and Prevost (1982) forecast a reduction in resources now devoted to community mental health services as resources are redistributed to the states to other important and pressing needs. Further, these administrators argue, the trend to provide fewer dollars to a broader range of services will place constraints on all human service providers in the next decade. The present article reports on the first phase of a comprehensive research program designed

to meet the needs of human service managers for guidelines and concrete action strategies for dealing with such a turbulent funding environment.

Method

The Delphi Process

A Delphi process was adopted as a means for identifying the most important steps which local CMHCs could take to survive cutbacks. Delphis have been used extensively in social psychology, urban planning, and other disciplines, and have been shown in laboratory and applied research to consistently provide analyses and recommendations concerning complex social problems which are superior to the best estimates of any individual expert (Ascher, 1978; Linstone & Turoff, 1975). The Delphi is particularly well suited for topical areas such as survival strategies in which accurate information is unavailable or expensive to obtain (Ascher, 1978; Linstone & Turoff, 1975).

The Delphi process is a method which structures group communication in such a way that a panel of experts can pool their knowledge to deal with a complex problem. The method involves a panel of experts answering a series of questionnaires, with the content of each questionnaire built on the results of the previous one in the series (Delbecq, VandeVen & Gustafson, 1975). A questionnaire in each step is sent to all members of a panel, who work on it independently and return their answers to the research team. The research team then reviews the responses to eliminate duplication, combine logically related comments, and clearly represent each of the ideas presented by the panel. The Delphi process begins with broad problems or questions, and works with each subsequent questionnaire to a narrower focus as consensus is reached by panel members. Davis (1982), in describing the Delphi

process, points out that after several cycles of questionnaire administration, almost all points of view emerge and opinions may converge on major issues. He views one of the primary advantages of this technique is its ability to uncover important issues not perceived by members of the research team. A representative Delphi panel will generate more divergent views and increase the probability that the consensus reached will reflect indigenous diversity.

The Delphi Panel

The Delphi panel selected for this study was composed of 106 mental health professionals with knowledge of CMHC cutback management issues. Representatives were drawn from four groups: (1) executive directors of CMHCs which had not received federal community mental health funds for at least the last four years ("old graduate"); (2) executive directors of CMHCs which had been terminated from the eight year CMHC program within the last three years ("recent graduates"); (3) executive directors of CMHCs which were in their seventh or eight year of federal funding and were facing imminent cutbacks ("pregraduates"); and (4) technical experts, and state, county, and federal officials with responsibilities for oversight of CMHC services. Two selection pools were used in developing a panel. All 44 participants in a 1980 NIMH-sponsored workshop (Woy & Mazade, 1982) which focused on problems of graduate CMHCs were asked to become panelists. Participants in that conference were carefully selected by NIMH staff to be representative of the following perspectives: CMHCs of various ages, organizational arrangements, and geographic locations (n=18), state, local and federal

officials with responsibility for CMHC services, and technical experts with specialized knowledge of CMHC fiscal administration and program management (n=26) (see Woy & Mazade, 1982, for more detailed information on panel selection). Executive directors of 62 additional CMHCs were invited to participate in order to broaden the panel to include more CMHC-based administrators with direct experience in dealing with funding cuts. Centers were included in the study if they were in at least their seventh year of federal assistance, or had graduated from federal CMHC operations grants. Earlier studies (Wasserman et al., 1981; Weiner-Pomerantz et al., 1979) had indicated that CMHCs which had received operations grants would experience more severe dislocations after federal defunding. Unlike CMHCs which had graduated early in the federal community mental health program, few agencies receiving operations grants had the cushions of large preexisting organizations such as hospitals, to buffer the loss of federal funds. The final Delphi panel included 18 representatives of old graduate centers, 26 from recent graduate centers, 36 from pregraduate centers, and 26 non-CMHC based experts and officials.

Procedure

In the first round, panel members were asked to describe actions which individual CMHCs or groups of agencies could take to prepare for the loss of federal funds. Areas suggested to panelists in which actions might be conceptualized were treatment modalities, mix and location of services, staffing patterns, personnel policies, finance and business practices, board membership and board activities, and

environmental monitoring. A total of 29 useable questionnaires were returned, yielding a return rate of 27%. This is an acceptable rate given the nature of the task, and the quality and diversity of responses provided (Ascher, 1978; Linstone & Turoff, 1975).

All responses were reviewed by the research team using the procedures described by Delbecq et al. (1975). The aim of the research team was to eliminate duplication and overlap, to arrange logically related ideas, and to represent each of the ideas presented by the panel. The resulting list of 77 specific strategies was sent to each of the panelists for the second round. The primary task of Round Two for each panel member was the rating of each strategy on four dimensions: importance, desirability, feasibility, and validity. A four point scale with written descriptive anchors was provided for each dimension. A total of 56 questionnaires were returned, yielding a return rate of 53%. Average ratings on each of the dimensions were computed, and the 77 strategies were rank ordered according to their total average score across all four dimensions.[4]

For Round Three panelists were instructed to rank the 15 strategies which they felt were most critical for weathering cutbacks. A score of one indicated the most important strategy, a score of two the second most important, etc. In Round Three 55 questionnaires (52%) were returned. Overall rankings were computed by assigning each strategy ranked #1 a total of 15 points, ranked #2 a total of 14 points, etc. The top 15 strategies from Round Three were compared with the results of Round Two. The results indicated that substantial consensus had been reached, and the Delphi process was terminated.

Results

This report will focus primarily on the top 15 strategies as ranked in Round Three. We will briefly report characteristics of some of the middle and lower rated items. A detailed description of the 77 strategies generated in Round One is presented elsewhere (Goplerud, Walfish, & Apsey, in press).

Return rates for the second and third rounds were double that of the first round. In particular, the return rate for recent graduates increased from 8% in Round One to 58% in Round Two. Part of the increase may be accounted for by differences in the difficulty of the panel's tasks: in the first round panelists were required to generate strategies in response to broad, open-ended questions. In the second and third rounds, the tasks were more reactive, that is, ranking and weighting strategies aleady provided.

The possibility of systematic differences between panelists representing different organizational perspectives was probed by comparing ratings from Round Two for each action strategy. In each analysis, the number of significant comparisons fell below the number that chance could not be ruled out. For example, out of 77 comparisons of the ratings of CMHC-based and nonCMHC-based panelists, only two items received significantly different ratings. Ratings of only three items differed significantly between CMHC-based panelists from states which mandate mental health coverage to be included in group health insurance plans from panelists from states which have no such requirements. Only one comparison differentiated between CMHC-based

panelists from states which permit CMHCs to bill Medicaid for services provided from panelists from states without such provisions. Ratings of old graduate, recent graduate, and pregraduate CMHC-based panelists were compared using oneway ANOVAs. Not one reached the significance criterion set ($p < .01$), although seven comparisons reached the $p < .05$ level.

The curvival strategies tapped a set of very important issues: 68 received average ratings on the importance scale of 3.0 or above on a 4 point scale. On the dimension of desirability or potential benefit of the action, 64 were rated above 3.0. Also, 60 of 77 received ratings above 3.0 on the validity scale, and 53 were rated above 3.0 on feasibility. Overall, 59 of the 77 items received an average rating, summed across the four scales, of 12.0 or above out of 16.0, indicating a pool of items which agency directors, NIMH staff, technical experts, and state and local mental health officials agreed were important, desirable, valid, and generally feasible.

Rankings of the top 15 strategies from Round Three were compared to rankings based on overall ratings of the four dimensions from Round Two. There was remarkable stability in rankings: 11 of the top 15 strategies identified in Round Three were among the top 15 highest rated strategies in Round Two. Three of the four highest rated strategies in Round Two appeared again in the top four of Round Three. Brief summaries of the top 15 strategies of Round Three are presented in Table 1. In addition each of the 77 action strategies are presented in Appendix A, along with priority rankings within each general category as well as overall ranking.

Insert Table 1 About Here

Discussion

The present turbulence in government funding and regulation of human services has abruptly forced many community mental health organizations to confront critical survival issues. The strategies identified in the present study focus on actions which are under the control of local agency boards, administrators, and staff, and which should improve an organization's ability to survive and even thrive during times of competition for scarce service funds. The action steps identified have been heuristically divided into internal organizational management and external environmental management strategies. Further subdivisions are made within these two broad categories.

Internal Organization Management

During cutbacks, hard and often unpopular decisions have to be made. Charles Levine (1980), in a thoughtful article on the problems of cutback management in public services, summarized a recurring tone in the Delphi panel comments: "Simply put, it is just not as much fun working and managing in a contracting organization as it is in an expanding one" (p. 180). Unfortunately, in many agencies, cutback management is not a choice but a necessity. Internal management strategies to weather cutbacks have been grouped into five subareas: information systems, priority setting, services, personnel, and financial and business practices.

Information systems. Far and away the most highly rated strategy on both Rounds Two and Three is the development and maintenance

of a sound accounting and management information system (MIS). On each of the four dimensions of importance, desirability, feasibility, and validity, this strategy was rated either first or second of all 77 items. Not only is there consensus about the significance of this strategy for agency survival, there is also consensus that the implementation of accounting and MIS procedures is highly feasible and within the control of local agencies.

Training materials are readily available on the development of MIS and public not-for-profit accounting system (see Broskowski, 1976; Cooper, 1974; Lee & Johnson, 1977; Matthews, 1977; Silvers & Brahalad, 1974; Smith & Sorensen, 1974; Sweeny & Wisner, 1975; United Way, 1975). Graduate level training programs have been established in a number of universities (see White, 1981 for a listing of programs) and training is a focus of continuing education programs conducted by NIMH and the National Council of Community Mental Health Centers.

Despite the availability of models and training opportunities, many organizations limp along with inadequate systems which provide unreliable and unuseable data (Naierman, Note 1). Conceptually, accounting and information systems can be simple. They provide information useful for four classes of management responsibility: (1) accountability to external funding sources, regulatory bodies, consumer groups, and other contituencies; (2) monitoring, controling, and integrating the deployment of current resources; (3) attracting resources for current and new programs; and (4) evaluating current programs, and planning new ones (Broskowski, 1976).

Information systems have several inherent limitations. Somewhat

paradoxically, the design of an information system presupposes that the uses of the data to be generated are already knnwn. An appropriate homily, attributed to Mark Twain summarizes the problem: "Statistics are a lot like garbage. Before you collect it, you'd better know where you're going to put it." The rapid changes in the external funding and regulatory environment can easily make an adequate system obsolete. Systems must be continuously monitored for the utility, timeliness and efficiency of data gathered in view of the constantly shifting reporting and reimbursement requirements of government agencies, third party payors, accrediting bodies, and other constituencies.

Information systems can not substitute for value judgments about policy and long range planning, although they may help to clarify policy and make values more explicit. One agency director on the Delphi panel who had been successfully running a graduate CMHC for many years observed: "I fear that there is an idea among many mental health center managers that somehow the financial problems facing us can be resolved by installing modern management information systems. This, of course, is not the case. While a sound accounting system and management information is a sine qua non, management systems are only tools, not ends in themselves" (Sivley, Note 2). Two inherent design limitations of information systems are critical. First, an MIS can only reflect past program efforts. It cannot determine or dictate the nature of future efforts. Someone or some group must lead and make necessary and appropriate decisions based on the data. Secondly, although informatin systems may help organizations determine costs and outputs, they can not determine if the efforts were worth

while from the viewpoint of clients, staff, managers, or other constituencies (Broskowski, 1976). The emphasis on implementing or improving information systems stressed by the Delphi must be linked with other survival strategies: prioritizing services, effective use of personnel, improved business practices, and means for monitoring and influencing the outside environment. After all, accounting and information systems can only count, sort, and categorize things. Board members, managers, and staff must make decisions based on the information.

Priority Settings. The prospect of serious funding cuts requires more than the ability to accurately and promptly sort and count. Difficult choices must be made about services, staff, and clients. The strategies ranked third, seventh and eighth reflect the importance placed on prioritizing services for cutbacks and expansion. One panelist, director of a recent graduate CMHC, observed: "It is important that we prioritize services not only to plan what we will continue to provide, but also to justify what we will not do, and why" (Iekel, Note 3).

As agencies come to reply on nonfederal sources to support services, and experience pressures to shift programs to match the priorities of their funding sources, it becomes essential to carefully engage in strategic planning. The alternative is to chase the shifting priorities of potential revenue sources. In the first round of the Delphi, quite a few of the current fads in community mental health were suggested: targeting consultation/education services toward business, developing employee assistance programs, even exploring

nonhuman service related ventures which might generate profits which could be plowed back into the agency. All of these actions received comparatively low ratings in the second and third rounds. Instead, there was strong consensus which emerged about the importance of generic strategic planning which is firmly based in a reassessment of the mission and goals of an agency, and a comprehensive review of all services provided.

With shifting priorities of funding agencies and cutbacks of federal, and in many places state and local funds, agencies may have to leave traditional core services and acquire quite different staff and programs in order to remain viable. At the same time, it may be necessary to lay off or transfer staff, refuse service to clients and disappoint constituents who had supported previous service arrangements. While undoubtedly there are many dimensions on which programs may be evaluated for possible cutbacks or expansion, five appear critical: (1) What is the program's relationship to the agency's mission, and the values and commitments of the organization's board and staff? (2) How is the program valued by important groups outside the agency who have interest, power and/or funds to support the agency or program? (3) What is the reasonable potential of the program to generate funds during the next term (one to two years) and longer term (three to five years)? (4) What is the level of expertise of existing personnel in the program, and the quality of services provided by that program? and (5) How available elsewhere are the services provided by the program if the agency no longer provides them? Several models of strategic planning are available (e.g., Demone & Harshberger, 1973; Feldman,

1980; Steiner, 1979), and the present authors are engaged in a series of studies designed to identify effective planning strategies explicitly tailored to the needs of human service agencies.

While much of the focus during austere times is inevitably on cutbacks, it is equally important for the future health of human service organizations that attention be placed on potential new markets and new or expanded services which could be developed. The same criteria used to evaluate programs for cutbacks might also be fruitfully applied to new areas where the feasibility of investing time and resources to develop new programs could be assessed.

Administrative functions as well as service programs should be reviewed during strategic planning to determine if an agency, or a group of agencies within a locality, is making the best use of the resources available. Interorganizational linkages around such areas as purchasing, pooled insurance, personnel administration, colocation of personnel, and shared services may reduce costs and increase accessibility to services. The elimination of some federal regulations and the pressure from cutbacks to identify means to reduce costs may encourage greater use of linkages, agreements, and trades between human service organizations. Broskowski (1980), Broskowski, et al., (1982), and Gans and Horton (1975) discuss the conditions which favor linkages, and the costs and benefits of a wide range of potential links between human service organizations.

Services. While the provision of services is the primary mission of CMHCs, the specific types and the mix of services vary greatly from setting to setting, and over time in individual centers.

As a strategy to promote agency survival during cutbacks, the Delphi panel ranked 74th out of 77 a recommendation to "maintain the services which are traditionally part of the community mental health ideology, e.g., the 12 services mandated by P.L. 94-63 or the JCAH balanced service system." Acknowledging that movement from tbe comprehensive service model would mean reducing or eliminating services to some people who would have no other place to turn, the panel ranked the recommendation to prioritize services for cutbacks and expansion as third in overall importance. Reducing the qualification level of staff, and potentially reducing the quality of services provided in order to maximize the amount of services available is not recommended by the panel as an effective strategy during periods of turbulence. Ranked 76th was a recommendation to maximize the amount of services provided by employing paraprofessionals or bachelors or masters level clinicians. Rated almost as low (60th) was a recommendation to retain the breadth of services provided while reducing first the quantity of services provided in various components. Instead, several of the highest strategies (numbers 3, 7, 8) suggest the importance of careful consideration of program costs and revenues in light of agency priorities. Unless strong political or agency value commitments far outshadow financial losses, programs not financially or programatically viable should be probably reduced or eliminated.

Clearly, there is consensus that at the local level, the comprehensive CMHC model may not be financially viable during austere times, or at least, that each agency would do well to carefully reassess its priorities rather than continue unthinkingly to provide

comprehensive services. To retain the model of a mix of prevention, intervention and rehabilitation services which are available and accessible to all parts of the population may require lobbying activities at state and federal levels which are beyond the resources of local agencies. Potentially, a very important function of national professional organizations, such as the American Psychological Association, the National Council of Community Mental Health Centers and the American Psychiatric Association and advocacy groups such as the National Mental Health Association, is to elicit governmental support through legislation, regulation and funding for models of services, or for components which it is clear that local agencies cannot support from local resources. Two areas particularly vulnerable at local levels unless supported at state or national levels are prevention and early intervention activities.

In one program area, maximizing services which are first and third party reimbursible, the panel made several specific recommendations. On Round Three, four of the top 15 strategies involve expanding services which produce first and third party revenues (numbers 6, 10, 11, 12). Emphasis on all relevant facets of providing such services were recommended: providing services specifically geared to generate third party revenues (e.g., outpatient psychotherapy by properly credentialed therapists, inpatient treatment in licensed facilities, special services under contract to vocational rehabilitation or criminal justice, etc.); hiring highly qualified staff with proper credentials which permit third party billing; developing screening procedures to identify clients with potential coverage and then channeling them to appropriate services and clinicians; and developing

ERIC

the necessary business office routines to efficiently bill third parties, using proper forms and procedures to assure prompt reimbursement. With the elimination of direct federal funding of community mental health and substance abuse services, the panel specifically recommended agencies actively pursue the expansion of insurance and private fees as a primary means for coping with cutbacks which is under local control.

Personnel. One key to organizational survival during austere times is to retain highly skilled staff who work efficiently and effectively on tasks which benefit the agency. Three strategies focus on different aspects of personnel policies: (1) retain a skilled, flexible management team; (2) develop productivity standards which assess quality, efficiency and effectiveness of work performed; and (3) hire highly qualified therapists and assign them clients which allow recovery of insurance.

A critical problem of organizational survival during contractions is the "free exiter" (Levine, 1980). During cutbacks, certain staff are vital for the continued smooth functioning of an organization, e.g., effective managers, skilled supervisors, talented clinicians. Yet, these are the very people with the greatest employment mobility, and the least incentive for remaining in a contracting organization where promotions, salary increases and expanded responsibilities are likely to be blocked by cutbacks. Leaving for more lucrative or interesting jobs, these free exiters take with them critical skills and knowledge which are usually very hard to replace, especially in a contracting organization. For agency survival during cutbacks,

the three personnel strategies emphasize means for identifying and limiting the free exiter problem.

As part of the priority setting process, agencies should identify the critical tasks necessary for the maintenance and growth of the organization. If tasks are not contributing, they should be eliminated. If tasks are necessary, they should be done as effectively and efficiently as possible. The staff carrying out key tasks should be retained and rewarded. Particularly critical in this reagard is the development and maintenance of the top management team, whose jobs by necessity are critical to the survival of the organization. Other criteria of key staff might include specialists with a skill that would be very difficult to replace, consistently high performers, or generalists who are able to perform a range of activities.

Where it can be done, productivity standards should be developed. Ideally, standards should be measurable, reliable, valid, and balanced. Unfortunately, little is known about productivity measurement or improvement in human service settings, and systematic research is necessary to better define dimensions of human service work which are accessible to productivity and performance appraisal. Field studies suggest that only 50% of clinical staff time in CMHCs is spent in direct clinical service, and a third of clinical staff time goes into interla nonclinical activities (Glasscote & Gudeman, 1969). In private group and individual practice, clinicians devote 70% or more of their time to direct clinical service. Since personnel is the primary factor that determines the quality of service and management, and accounts for 80% to 85% of most human service expenses, it is very

important that these resources be developed and used effectively.

Linked to productivity, incentives should be developed to assure that staff performing key tasks continue in the agency. Incentives might include more compensation, employer paid benefits, professional benefits that are not taxed (e.g., travel, professional conferences, professional dues), or flexibility in job assignments. In its ratings, the Delphi panel indicated a clear preference on how to resolve what Levine (1980) called the "productivity paradox". The paradox, according to Levine, is that to improve productivity, organizations must invest scarce resources to acquire skilled staff, to train and upgrade staff skills, and to organize systems which make the best use of personnel. It takes money to save money through increases in productivity. Under conditions of austerity, it may be difficult to find and justify funds to invest in productivity improvement or retraining skilled staff, especially if these funds can only be made available by laying off employees or failing to fill vacancies. To successfully weather cutbacks, the consensus of the Delphi panel indicates, agencies must retain the best possible service and management staff. Agencies must be willing to cut some weak programs and some weak staff to hold and improve areas of agency strength. Use of "across-the-board" cuts in salaries or program expenses do not encourage the best staff to remain committed and thus will ultimately work against the long range success of the agency.

Business Practices. Four strategies in the top 15 involve improvements in business practices: installing systems to bill third party payors (#6); tightening financial screening procedures to assess

ERIC

client income and ascertain third party coverage (#12); reviewing and regularly revising fee schedules (#15); and maintaining operating reserves to buffer cash flow problems (#14). The first three focus on an area in which public human service agencies have traditionally been lax: collections. Naierman et al., (1978) found that when CMHCs began to improve procedures to capture first and third party revenues that are usually lost through haphazard financial screening of clients, unassertive billing procedures, and ineffective insurance collection efforts, revenues from these sources typically jumped by 300% or more in the first year. After two or three years of rapidly rising collections, gains stabilize unless an agency changes the mix of services provided, the kinds of clients served, or there are significant changes in the regulatory environment (e.g., changes in state Medicaid or Medicare coverage or in insurance regulations). To build up expertise in insurance billing procedures, to improve fee collection practices may require agencies to again confront the productivity paradox, since the implementation of new systems generally requires expenditures up front in new staff positions or retraining existing staff. But, to survive in a turbulent financial environment, investments must be made in financial policies and procedures which can maintain accountability to multiple funding sources and provide the financial reserves and expertise needed to prosper in times of competition for scarce human service funds.

Environmental Monitoring

The source of much of the turmoil affecting community mental

health services derives from decisions made outside local agency boundaries. It is hardly a surprise that three of the top strategies explicitly involve monitoring and changing the environment outside an agency (#5, 9, 12). Many of the others imply interaction with external actors (e.g., #1, 3, 7, 8, 11, 14).

A primary vehicle for influencing the environment outside an agency is its advisory or governing board. Members should be selected to build or strengthen coalitions with powerful groups in an agency's environment or to gain access to influential constituencies. Since staff and board members have a finite amount of time and energy to devote to linkages, it is important that linkage efforts be targeted effectively. A careful review, perhaps conducted annually, of the relationships an agency has, or should have, with powerful groups in the environment can help the agency key in on the 10 or 15 linkages which are particularly important for the survival and growth of the agency. In addition to surveying the environment for important organizations and linkages, an agency would do well to identify what kinds of linkages are desirable, and who should initiate and maintain the relationships. Some, such as county and state legislators, may respond best to contacts by community board members, while others such as state mental health officials, medical school deans, or hospital administrators, might be better approached by agency staff.

Board members should be systematically polled for contacts which can help the agency. Board members can help identify and assist with the recruitment of new board members, detect shifts within the community which might affect the center or provide opportunities for new programs,

uncover funding opportunities, such as potential contributors to fund raising campaigns, or work directly with legislators or other key groups to lobby for the agency. Since boards generally are responsible for policy, and many of the top strategies listed so far have policy implications, it is vital that during periods of cutbacks that agency boards be able to make and stick to tough decisions. This means that boards must develop the range of professional sophistication to enable them to deal appropriately with a very competitive market place. It would be unreasonable to expect that CMHCs, which have average budgets in excess of two million dollars per year, and an average staff of 130 (NIMH, 1981), could function effectively with anything less than a sophisticated board and professional administrators. Particularly helpful as board members are local businessmen with good administrative or financial experience, physicians with influence in the medical community, and lawyers and others with access to political leaders and regulatory officials.

The managers of human service organizations must also be heavily involved in environmental management. Access to a wide variety of funding sources often means accommodating to conflicting objectives. Developing services to meet the priorities of one funding source may preclude access to other potential funding avenues. For example, heavily focusing agency services toward state, Medicare and Vocational Rehabilitation supported programs for chronically mentally ill persons may virtually exclude an agency from first and third party supported outpatient psychotherapy programs for middle class adults and their families. An aggressive fund raising program may fail if the community

perceives an agency to be a public welfare program of the government. Agency administrators must choose among options available, looking for the long range implications of choices on the organization's missions, plans for services, and financial growth projections. Operating at the boundaries between the organization and numerous other systems, the CMHC manager is continuously engaged in complex negotiations with other parties who have differing constituencies, control over resources, and bargaining leverage.

Regardless of which options are chosen or forced on an agency, its administrators should develop close relationships with major funders, and work with them to influence their ideas, programs, regulations, and funding decisions. It should be a priority of agency directors to know personally key state legislators, county commissioners, state mental health officials, and others who can directly shape the external environment of the agency. It is something of a paradox that agency directors must delegate most of their authority for control over internal management issues to subordinates in order to focus their efforts into external environment management where their authority is very limited. Joining with other human service organizations in coalitions may increase an organization's ability to influence its environment.

While influencing decisions to benefit one's agency is important, perhaps equally important for CMHC survival is the development of an information network which can pick up subtle shifts in the environment which may affect the agency at some point in the future. By catching trends early, agency administrators and boards can position their

organizations to take best advantage (or minimize the damage) of external changes which are beyond their control. Through contacts at the state and local levels, agency administrators should stay forewarned about legislative and regulatory changes so that center programs can be adapted to capture potentially available funds without violating the agency's priorities. In some states, for example, state mental health officials have become concerned in recent years with the low level of community-based rehabilitation services available for chronically mentally ill persons, and about the lack of continuity of care between the state hospitals and the CMHCs. When funding and regulatory responsibilities shifted to the states, matching the priorities of the state mental health bureaucracy became critical for the survival of many local agencies. Consequently, those organizations which already had read the increasing state priority of services to chronic patients and had developed psychosocial rehabilitation programs, probably experienced far less dislocation of staff, services, and funding than did agencies whose services did not match those that the states were most interested in buying.

A Concluding Note

The Delphi process has centered attention on several key areas in which agencies can act to cope with cutbacks. The 15 top strategies are not, however, a formula for survival and growth. There are just too many variables in local environmental constraints and individual agency capacities for any one recipe to be applicable in all instances. Rather, the results of this study were developed to be used as a guide for agency self-evaluation. An agency's management team could review the strategies and identify persons or groups who would be responsible for judging the agency's performance against specific strategies. For example, a committee of the Board might be assigned the task of developing a long range plan which includes service priorities, overall agency missions, and policy recommendations. The chief financial officer and the executive director might address the financial management and information system issues identified. Service program managers could address issues of staff productivity, service modalities, and service locations. The assignment of tasks and the specific results of the assessment should vary considerably from agency to agency.

Another use of the results is as a guide for new managers and students interested in careers in human service administration. The top strategies suggest a training curriculum which supplements general public management training by indicating areas for special emphasis. The Delphi results also provide a focus for case materials and practical problems which new managers should be trained to handle.

Similarly, there are clear extensions from the Delphi to training guidelines for agency boards:

The present study is only the first phase of a larger project to develop effective means for assisting local agencies to cope with the uncertainties of the next few years. Presently research is under way to identify potential barriers to implementing the general survival strategies outlined in this article, and to develop methods for overcoming these barriers. Other studies focus on long range planning techniques in local human service agencies, internal sources of resistance to agency changes during cutbacks, methods of performance and productivity assessment in human services, and changes in state-level mental health planning and regulation since the passage of the Omnibus Act. The final product of this program will be specific training materials focused on the most important survival issues. By training agency managers and future managers in effective methods for weathering financial hardships, community mental health services may emerge better managed, better supported locally, and more closely tied into local needs and priorities. The alternatives--reduction of services, weakening of program staff quality, and financial instability--are well known.

ERIC

Reference Notes

1. Naierman, N. Personal communication, April 15, 1982.
2. Sivley, R. Personal communication, February 16, 1982.
3. Iekel, J. Personal communication, March 12, 1981.

ERIC

References

Archer, W. Forecasting. Baltimore: Johns Hopkins University Press, 1978.

Broskowski, A. Management information systems for planning and evaluation in human services. In M. C. Schulberg & F. Baker (eds.), Program Evaluation in the Health Fields, Vol. II. New York: Human Sciences Press, 1976.

Broskowski, A. Evaluation of the primary health care project-community mental health center linkage initiative: Final report. Rockville, Md.: National Institute of Mental Health, 1980.

Broskowski, A., O'Brien, G. & Prevost, J. Interorganizational Strategies for Survival: Looking ahead to 1990. Administration in Mental Health, 1982, 9, 198-210.

Cooper, E.M. Guidelines for a minimum statistical and accounting system for community mental health centers (NIMH Mental Health Statistics Methodology Reports, Series C, No. 7. DHEW Pub. No. (ADM) 74-14), Washington, D.C.: U.S. Government Printing Office, 1974.

Cunningham, S. Fate of social research is real secret of NIMH, A.P.A. Monitor, 1982, 13 No. 10, 1, 28.

Davis, D. Participation in community intervention design. American Journal of Community Psychology, 1982, 10, 429-446.

Delbecq, A., VandeVen, A. & Gustafson, D. Group techniques for program planning. Glen View, Ill.: Scott, Foresman, 1975.

Demone, H.W. & Harshbarger, D. The planning and administration of human services. In H.C. Schulberg, F. Baker, & S.R. Roen (Eds.), Developments in human services (Vol. 1). New York: Behavioral Publications, 1973.

Feldman, S. (Ed.), The administration of mental health services, (2nd Ed.) Springfield, Ill.: Charles Ce. Thomas, 1980.

Gans, S. & Horton, G. Integration of human services. New York: Praeger, 1975.

Glasscote, R. & Gudeman, J. The staff of the CMHC: A field study. Washington, D.C.: The Joint Information Service of the APA and the NIMH, 1969.

Goplerud, E., Walfish, S. & Apsey, M. Surviving cutbacks in community mental health: Seventy-seven action strategies, Community Mental Health Journal, in press.

Lee, R.D. & Johnson, R.W. Public budgeting systems, (2nd Ed.). Baltimore: University Park Press, 1977.

Levine, C. Managing fiscal stress: The crisis in the public sector. Chatham, N.J.: Chatham House Publishers, 1980.

Linstone, H.A. & Turoff, M. (Eds.), The Delphi method: Techniques and applications. Reading, Mass.: Addison-Wesley, 1975.

Matthews, L.M. Practical operating budgeting. New York: McGraw-Hill, 1977.

Naierman, N., Haskins, B. & Robinson, G. Community mental health centers: A decade later. Cambridge, Mass.: Abt Associates, 1978.

NIMH, Survey and Reports Branch, Division of Biometry and Epidemiology, Provisional data on federally funded community mental health centers: 1978-1979. Washington, D.C.: Author, September, 1981.

Sarason, S. The creation of settings. San Francisco: Jossey Bass, 1972.

Silvers, J.B. & Brahalad, C.K. Financial management of health institutions. New York: John Wiley and Sons, 1974.

Smith, T.S. & Sorensen, J.E. Integrated management information systems for community mental health centers (DHEW Pub. No. (ADM) 75-165). Washington, D.C.: U.S. Government Printing Office, 1974.

Sorensen, J.E. & Phipps, D.W. Cost findng and rate setting for community mental health centers: Methodology reports. Rockville, Md.: NIMH, 1972.

Stapp, J., Fulcher, R., Nelson, S.D., Pallak, M.S. & Wichenski, M. The employment of recent doctorate recipients in psychology. American Psychologist, 1981, 36, 1211-1254.

Steiner, G.A. Strategic planning: What every manager must know. New York Free Press, 1979.

Sweeny, A. & Wisner, J.N. Budgeting fundamentals for nonfinancial executives. New York: AMACOM, 1975.

United Way of America, Budgeting: A guide for United Ways and not-for-profit human service organizations. Alexandria, Va.: United Way of America, Systems Planning and Allocation Division, December, 1975.

Wasserman, D., Woy, R. & Weiner-Pomerantz, R. Movement away from the model: Community mental health centers after federal funding. Community Mental Health Journal, 1981, 17, 265-276.

Weiner, R., Woy, R., Sharfstein, S. & Bass, R. Community mental health centers and the "seed money" concept: Effects of terminating federal funds. Community Mental Health Journal, 1979, 15, 129-138.

White, S.L. Managing health and human services programs: A guide for managers. New York: Free Press, 1981.

Woy, R. & Mazade, N. Community mental health centers in transition: Report on a national conference. Administration in Mental Health, 1982, 9, 211-224.

Table 1

Top Fifteen Action Strategies

Rank	Strategy
1	Develop and maintain a sound accounting and management information capacity
2	Retain a skilled flexible management team
3	Prioritize services for cutbacks and expansions
4	Develop productivity standards
5	Use agency board to build coalitions, gain access to influential constituencies, and increase center's financial stability
6	Install systems to bill third party payors
7	Adapt center services and priorities to new conditions
8	Review service programs and administrative functions to assess whether organizational configuration is most cost-efficient
9	Develop a fund raising capacity
10	Emphasize services which will maximize third party and private fees
11	Hire clinicians that insurors will reimburse, and assign clients to staff and services which will allow recovery of costs
12	Tighten financial screening of clients
13	Influence regulatory policy through contacts at the state and local level
14	Maintain operating reserves to buffer cash flow problems
15	Establish and revise your fee schedule

Appendix A

Ranking within Category and Overall Ranking of 77 Strategies to Weather Cutbacks

From Round Two of Delphi Survey

Rank within Major Category		Overall Rank
	SERVICES	
1.	Prioritize services for cutbacks and expansions.	4
2.	Accurately assess the full cost of services and retain those that pay for themselves.	31
3.	Use mass media effectively to promote center services.	35
4.	Focus on basic services - diagnosis and treatment.	48
5.	Retain programs which are high priorities of funding agencies, but only to the level they support.	52
6.	Cultivate middle class clientele by offering the professional services they expect.	53
7.	Foster self-help groups for people you can't serve directly.	56
8.	Sacrifice quantity of services provided before sacrificing program breadth or quality.	60
9.	Reduce or eliminate services which don't generate revenues to match expenses.	67
10.	Maintain traditional CMHC services.	74
	TREATMENT MODALITIES	
1.	Treatment should be based on diagnosis and need.	20
2.	Modify modalities to cut unit costs; es. group and family therapy.	43
3.	Provide a range of modes to match the community's ability to pay.	66
	CONSULTATION, EDUCATION ANO TRAINING	
1.	Redirect C & E towards revenue producing markets.	34

2. For nonrevenue producing C & E examine its advertising, marketing and public relations value. 37

3. Expand the capacities of others to reduce demands for CMHC services. 68

4. Transfer free C & E services to others outside the center. 75

STAFFING

1. Monitor mix of direct to indirect staff. 22

2. Hire more contract and part-time staff. 62

3. Hire generalists instead of specialists. 69

4. Hire paraprofessionals and nondegreed clinical staff when chances of insurance recovery are low. 76

PERSONNEL POLICIES

1. Retain a skilled, flexible management team. 3

2. Develop productivity standards. 13

3. Tie incentives to productivity. 39

4. Review fringe benefit packages. 47

5. Develop incentives for staff who bring in added revenue. 51

6. Review layoff policy to increase flexibility. 61

7. Use volunteers and students to augment staff. 64

8. Broaden hiring criteria to get good people. 65

9. Explicitly choose a personnel strategy either to retain experienced clinicians or encourage turnover. 72

10. Train managers to manage and not provide direct services. 73

LOCATION

1. Monitor costs and services in satellites very carefully. 11

2. Offer services onsite where possible to reduce overhead. 45

3. Acquire property to increase longterm stability. 54

4. Locate programs for full fee clients outside the center. 77

Cutbacks

FINANCE AND BUSINESS PRACTICES

		38
1.	Invest in a sound accounting and financial management capacity.	1
2.	Establish and revise your fee schedule.	5
3.	Maintain a flexible Management Information System (MIS)	6
4.	Maintain operating reserves to buffer cash flow problems.	12
5.	Develop incentives to encourage clients to pay for services at time rendered.	16
6.	Stress quick cash flow.	21
7.	Charge fees comparable to community rates.	24
8.	At most, develop a good three year plan.	23
9.	Prioritize nonbillable services.	25
10.	Develop a fund raising capacity.	26
11.	Improve collections on inactive accounts.	33
12.	Collections will increase when significant internal or external changes take place.	42
13.	Charge for services for a fee upfront rather than seek cost reimbursement after the fact.	57
14.	Involve therapists in billing and collections.	59
15.	Ration free services to the amount subsidized by government.	71

THIRD PARTY REIMBURSEMENT

1.	Install systems to bill third party payors.	2
2.	Tighten financial screening of clients.	15
3.	Emphasize services which will maximize third party and private fees.	27
4.	Hire clinicians that insurors will reimburse, and assign clients to staff and services which will allow recovery of costs.	38

OVERHEAD AND ADMINISTRATIVE COSTS

1.	Review all forms of insurance for savings.	30
2.	Examine advantages of not-for-profit status.	32
3.	New corporate configurations can help center hold property and explore surplus generating services.	50
4.	Consider the advantages of leasing versus purchasing capital equipment.	49
5.	Acquire capital assets, especially program facilities.	55

ROLE OF THE BOARD

1.	Comb through the Board for helpful contacts.	8
2.	Use Board to build coalitions, gain access to influential constituencies and increase centers financial stability.	9
3.	Boards should represent the community served.	44
4.	To be effective, Board members should be saturated with information about cutbacks.	58
5.	Disband the large representative Board for a small, powerful business-oriented Board.	70

MONITORING THE EXTERNAL ENVIRONMENT

1.	Influence regulatory policy through contacts of state and local level.	7
2.	Know major funders and legislators personally.	10
3.	Adapt center services and priorities to new conditions.	17
4.	Get on state, local mental health planning committees.	28
5.	Get involved in coalitions.	36

LINKAGES/CONTACTS

1.	Review service programs and administrative functions to assess whether organizational configuration is most cost-efficient.	14
2.	Coordinate services and linkages before termination of Federal funding.	18

		Cutbacks
		40
3.	Develop close contacts with local health providers.	19
4.	Develop close contacts with local industry.	29
5.	Work jointly with local service providers to attract funds into the community.	40
6.	Seek powerful allies, especially with strong financial reserves.	41
7.	Cultivate strong linkages with 10-15 powerful actors in the community.	46
8.	Plan strategic mergers to manage environmental instability.	.63

ERIC