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STAFFING AND ORGANIZATIONAL MODELS IN MENTAL HEALTH PROGRAMS

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ABSTRACT: Staffing is one part of an overall pattern of organizational functioning. Three organizational models—rational, political and standards—typically seen in mental health programs are described. Who is hired and why are examined in terms of the characteristics of each model. A summary of decision guidelines for staffing is provided, followed by suggestions for formulating a staffing strategy based on the models. Mixed models and models in the late 1980's are discussed.

INTRODUCTION

The majority of an organization's resources are related to personnel. Employee costs constitute two-thirds to three-quarters of an organization's operational budget (Shafritz, *et al.*, 1978). Despite the morass of personnel policies, budgetary constraints, accrediting standards and program requirements, many administrators believe they can find the right staff-to-client ratio or the ideal professional/administrator/paraprofessional mix. Most have come to the realization that there is no pat formula, no perfect classification system, which can address any given staffing need. Rather, each program has its unique problems and objectives which require a tailored approach to staffing.

The key to unravling the complicated process of staffing mental health programs is in understanding the intimate relationship between staffing and organizational functioning. The most important task in staffing is to define what is to be done and who is to do it. Once the organization is understood in terms of its dominant pattern of operation, staffing can be perceived as an extension of that pattern.

This article is divided into two sections. The first section presents three models of organizational functioning so that we may more readily understand why the

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staffing process varies so widely in different settings. Examples of typical staffing concepts for each model are offered. Quotes from interviews with six mental health administrators are interspersed throughout the text. The adminstrators were chosen because they represent a variety of organizations. All the interviewees were asked to respond to the first section of this paper in terms of their own experience. The interviews were structured around eleven questions and were mailed to the administrators prior to their interviews. The average length of each interview was one and one-half hours. Respondents were mailed the final draft of the interview in order to verify the accuracy of the authors' notes.

The second part of this report contains some decision guidelines for staffing based upon the analyses and the administrator interviews we have obtained. These "rules of thumb" are speculative in nature until the data can be obtained to test them. They serve as a summary of information as well as a brief recapitulation of recommendations from working administrators. Following these decision guidelines, the authors offer a method for developing an effective staffing strategy. They also discuss mixed models and speculate about evolving models in the late 1980s.

UNDERSTANDING STAFFING THROUGH ORGANIZATIONAL MODELS

Three organizational models—rational, political and standards—are helpful in understanding staffing in mental health programs. Each has its particular priorities which directly affect who is hired, how they are recruited and their basic tasks in the organization (see Table 1). While models are never a precise description of reality, they are a mechanism for comprehending it.

The Rational Model

In the rational model, actions are problem-centered and goal-directed. Decisions are tied to objectives, and the actors are consistent (Pfeffer, 1981). A major indicator of whether or not an organization is rationally-based is how it handles information in decision-making. A rational organization gathers data prior to a decision, not in support of it. The information itself is problem-focused, valid and reliable, documents the need for a solution and includes more than one set of actions for problem resolution (Chaffee, 1980). Two examples of the rational model in the mental health field are private nonprofit and private for-profit organizations.

An illustration of the rational model applied to staffing is the old and still controversial procedure of merit selection. Traditionally, merit selection has involved minimum qualification requirements, evaluation of training and experience, written tests, performance tests, oral examinations and background investigations. While each of these devices has come under criticism for a num-

TABLE 1
Characteristics of Organizational Models

	Rational Model	Political Model	Standards Model
What are the typical organizations for each model?	Private nonprofits. Private for-profits.	Public agencies.	Teaching hospitals, specialized and high risk programs, grant-in-aid programs.
What determines organizational behavior?	Administrative control.	Public control.	Professional control and accrediting bodies.
What is the basic organizational goal?	Cost-effectiveness.	Satisfying public needs.	Optimal quality of service.
How are decisions made?	Data-based planning.	Bargaining.	Conformity to standards.
What are the managerial tools?	Merit system, job classifications, personnel ranking, manpower forecasting, technical core.	Affirmative action, public relations, community organization.	Privileging, credentialing, standards manual.
How is organizational success measured?	Quality and quantity of output: Staff productivity and patient outcome (nonprofits). Earnings (for-profits).	Ability to get resources from environment and favorable public image: More land, labor, capital and public recognition.	Quality of output: Patient/client outcome, accreditation.
What is the strength of each model?	Efficiency, fiscal responsibility, competent staff.	Most available and widest array of services, accessible staff.	Highest quality service, expert staff.
What is the weakness of each model?	Cost concerns compete with patient needs. Comprehensiveness is sacrificed.	Least emphasis on patient outcome. Most vulnerable to external control. Most unstable service delivery in terms of services. Fewer professional staff.	Expensive. Based on belief rather than documented proof. Vulnerable to professional hegemony.

ber of reasons, the most salient is the issue of validity—do these devices accurately measure what they are intended to measure?

Advocacy groups have questioned the definition of merit in merit selection (Nigro & Nigro, 1981). They want to broaden it beyond competence to include equal opportunity, affirmative action and representativeness (Shafritz, Belk, Hyde & Rosenbloom, 1978; Nigro & Nigro, 1981). Merit systems have also been criticized for sanctioning poor performance.

Job classification, particularly position classification, has also been called into question. Some classifications are so rigid that descriptions prevent flexibility in managing work. Others are so flexible that it is impossible to determine how well or even if a job is being carried out. This is common practice in step raises and annual raises. Rewards are given for the structure of the job and how long an individual is employed at that position rather than whether he/she is performing effectively.

One of our interviewees, Mr. Bates, the director of a suburban CMHC with a budget of $3 million and a staff of one hundred forty-four, criticized the usefulness of the merit selection for his agency. He noted that:

> . . . Merit selection only works when the applicant is known since it is almost impossible to pick people that one has never met. At my agency, the probationary period is the merit test and it is more illuminating than selection devices because many jobs are based upon qualifications of the individual as opposed to a knowledge base. For example, one cannot predetermine who will be a good case manager or night supervisor by pencil and paper tests. I feel that the merit system contains a basic flaw in granting increments solely for completing another year. When the labor force is not remunerated for productivity but simply for being there, it tends to decrease its productivity.

Personnel ranking is used to decide how a particular candidate can be placed. The rational model defines two different kinds of placement—rank-in-person and rank-in-position. Rank-in-person implies a career orientation in that individuals are chosen for their long range potential while rank-in-position is based strictly on the duties assigned to a particular job. In mental health organizations, professionals tend to be ranked by person while support staff and paraprofessionals tend to be ranked by position.

Dr. Peters, the head of an adult inpatient service in an urban for-profit psychiatric hospital with a staff of twenty-four, stated that:

> . . . I like to find the best person for the job and I tend to use rank-in-person. I emphasize a group of skills rather than people who are essential to an organization. Positions are always replaceable and it is an inventory of skills that is vital to the organization.

Dr. Coleman is chief administrator of a psychiatry department in a large urban county hospital with a budget of $5.3 million and one hundred forty-seven employees. Although hiring by both rank-in-person and rank-in-position, he offers a twist:

> . . . I find that the rank-in-position is typically at the doctoral level where specific types of training and credentialing are required for upper-level jobs. However, at the lower levels, I have more flexibility. The vast majority of my Master's degree workers, except for nurses, can be defined in a general classification as "clinicians". I am able to interview people from a wide variety of backgrounds and choose the person best suited to the organization.

Another concept germaine to the rational model is manpower forecasting. The present staffing pattern can be used to project future needs by inventorying the current skills of the employees and matching them to the future needs of the organization. The mental health literature is replete with such manpower forecasting techniques as computer simulations and management information systems. Unfortunately, many of these tools have proven useless to mental health adminstrators particularly in the public sector because of their inability to predict or control the funding base.

Most of our interviewees debunked manpower forecasting. Dr. Lewis, the director of a state department of mental health with a budget of $250 million and sixteen thousand employees, commented that manpower forecasting has mostly meant cutting back:

> . . . Most forecasting is centered around the professions, psychiatry and nursing, that are scarcest in mental health. The budget determines how much money will be available for the next year and determines what kind of recruiting is necessary. Manpower forecasting has little use in a public setting because hiring is seldom based on either the rational or standards model.

In contrast, Mr. Bates, the suburban CMHC director, disagreed with most of the other administrators interviewed:

> . . . If one concedes that it is impossible to predict personnel requirements, he/she is admitting to an inability to run the organization. One can forecast need but not the resources available. Consequently, the administrator must plan for meeting minimum needs within his/her jurisdiction.

The technical core is another concept applicable to the rational model (Nalbandian & Klingner, 1981). Irrespective of political, legal, and accreditation demands placed upon organizations, there is a body of workers using a set of policies and procedures which effectively and efficiently produce outcomes congruent with objectives. We may draw an analogy between the technical core and a life support system. The survival of an organization is dependent upon at least "X" number of people doing the job for which they were hired. Thus, the administrator uses such a concept to determine essential versus desirable staffing patterns.

Dr. Lewis regards the concept of technical core as one which guides his own rationale for assignments: "Some employees whose assignments bear little relationship to job title are the people who most often effectively represent the needs of the organization." In fact, the idea of a technical core struck a responsive chord with two other interviewees. Dr. Peters and Mr. Bates both confirmed

their use of such a concept in their staffing positions, yet focused on a group of core skills rather than on individuals.

A clear example of the overall use of the rational model in staffing comes from Dr. Thomas, the director of a university-affiliated CMHC with a budget of $3.9 million and one hundred seventy-five employees:

> . . . I view staffing in terms of competencies and credentials. The merit system is useful for retention and salary increases. I utilize both rank-in-person and rank-in-position and fill a position at one time while grooming an individual for the agency at another. Manpower forecasting is only helpful in recruiting and hiring scarce staff such as nurses and psychiatrists.
>
> In order to avoid patronage, I hire a politically-sponsored candidate only if he or she is the best. Affirmative action is used solely to avoid discrimination even though I do not agree with the issue of representatives as a justification. Accrediting standards are relevant only when they are essential to the operation of the center. In other words, I will only use those standards that are reimbursable or enforced by legislation. Even then I am cautious in what standards I employ for my organization and would prefer to make up my own mind.

Strengths and Weaknesses of the Rational Model

The strongest arguments for the rational model are efficiency and fiscal responsibility. Personnel are hired and managed in terms of cost-effectiveness. Private for-profits and private nonprofits often function under this model. Whether a mental health organization is public or private is defined, of course, by ownership. While public funding is typically the major source of payment for public agencies, private agencies are supported by fee-for-service, gifts and grants from nongovernmental sources. Since agencies dependent upon fee-for-service are more directly affected by hours of direct contact, we would expect this measure of productivity to be higher for private agencies. Indeed, in a state-wide study of all community mental health agencies, one of the authors found a direct relationship between caseload and percent of private funding (Silverman, 1984). Similarly, Siegal, Haughland and Fischer (1983) reported that private inpatient services spend twice as much time in direct patient care proportionately than do public inpatient services. On the other hand, public facilities spend one and one-half more time on record-keeping and more time on nonjob related activities.

Rational model organizations emphasize direct service hours with less interest in such coordination activities as meetings and consultations. Accountability in administrative tasks as well as "dead time" are actively held to a minimum. Staff development and continuing education are viewed as the clinician's responsibility. We would expect that administrators would recruit personnel with marketable skills, the most desirable being individual psychotherapy. This form of treatment is still preferred by most laypersons and is the most acceptable to third-party payers.

The rational model has some obvious weaknesses. In nonprofits, staffing requirements may be so rigid or outdated as to be disincentives. Employee moti-

vation, compatibility and interest are difficult to assess with traditional civil service methods.

Some managerial tools from the rational model have been carried to extreme. Some have become too cumbersome as in the case of merit exams or too powerful as with manpower forecasting to be used appropriately at the organizational level. The "canned answers" that these tools often require have little to do with reality.

Under this model, cost concerns tend to override individual patient needs. Emphasis is placed on reimbursable services rather than the most useful services. While this stance may be beneficial to the continued well-being of the organization, consumers may suffer either by not receiving treatment because they cannot pay or because the treatment is too expensive for the organization to offer. Dr. Lewis commented on this problem in his interview:

> . . . The public arena offers adequate care that is comprehensive, accessible and affordable. The emphasis in private settings is quality and much less emphasis is placed on comprehensiveness or accessibility. Utilization becomes a very large factor because one has to have a certain volume to stay in business.

The Political Model

An organization functions as a political entity when actions are based upon compromise as opposed to definite goals and objectives (Pfeffer, 1981). The organization is viewed as pluralistic in terms of interests, with each subunit competing for its own interests. In the political model, this conflict is viewed as normal in that power as opposed to rationality determines actions. Since power in any given subunit is rarely absolute, no one subunit can have its needs fully met (Allison, 1971).

A key characteristic of political organizations is the role of opportunity-based decisions (Scheirer, 1981). Implementation is based upon what we can get permission to accomplish, as opposed to what should be accomplished. Bargaining is the central activity as opposed to the collection and interpretation of data in the rational model. Whereas success of rational organizations is measured by the quantity and quality of output, the political organization's success is measured by input, i.e., the ability to garner resources from its environment. In terms of staffing, resources may include money, employees, positions or independence from other subunits.

The basic argument in favor of the political model is that political entities are more responsive to the public. In fact, this model is most often found in public mental health agencies. Agency personnel who work at the behest of a public representative are more sensitive to citizens' needs than a civil service-appointed bureaucrat. Also, the elected official should have the opportunity to approve the people with whom he/she would be most comfortable and compatible in implementing the program. These are the core arguments for the staffing

method known as patronage. Job qualifications are secondary to the ability to give a valued service to the political organization.

A staffing process similar to patronage is affirmative action. Both are based on a concept of representativeness. The rationale of affirmative action is that certain subgroups are underrepresented in the work force and that these groups should be given special consideration in recruitment and hiring. While the "sins of the past" might be one argument for affirmative action, it is secondary to the notion that subgroups are better served by their own. One of the most successful examples of affirmative action has been in mental health, specifically in the implementation of the federal community mental health centers legislation. M. Silverman (1978) reported that one of the greatest impacts of the legislation was attaining a greater degree of similarity between the demographic background of the service providers and the populations they serve.

Dr. Coleman stated that affirmative action is an important staffing issue at his large county hospital:

> . . . One makes sure that the available population for a given job has been made aware of that job. If minority applications are not received, I vigorously and actively make the minority aware of the job. Beyond that, selection is based on who is best for the job. I am opposed to having an exact degree of representation on the staff as exists in the client caseload.

No one who has lived or worked in a major metropolitan area has not had some experience with machine politics. One of the more entertaining accounts is that of a newspaper reporter, Mike Royko. His book, *Boss* (1971), is a description of the Chicago political machine under the late Mayor Daley. His most telling criticism of the political process is the myth of representativeness. In one chapter, a parody on the Book of Genesis, Royko goes through a series of "begats" describing how political power gets passed down from father to son. Staffing decisions are based on who one is, who one knows, or how effectively one brings in the support necessary to keep it going.

Nepotism is not the only argument against the representativeness issue in political systems. In a series of cogent criticisms, Nigro and Nigro note that the power to formulate policy is not equally distributed among all employees and that ideological affinity with demographic groups is less important than agency affiliation. What emerges is a pattern of bureaucratic pluralism (agencies tied to interests) that aggregates into a normatively representative higher civil service.

One of our interviewees, Dr. Lewis, commented on this issue:

> . . . In a political model, maldistribution in hiring exists, not necessarily because of patronage, but because some political leaders have more clout and represent their constituencies more effectively. As a result, one may find County A with a program similar to that in County B but with twice as many employees.

Another criticism of political appointments is the tendency toward corruption in staffing. Shafritz, *et al.* used the term "nether-world" to describe the under-

the-table processes at play to circumvent policies on recruitment and hiring. Job announcements are publicized on short notice so that a preselected candidate is the only one to fill out applications on time. Positions are mysteriously upgraded to compensate a crony or positions are frozen to punish a program director. These antics are neither representative of, nor condoned by, the public, but are hidden from the daylight. In one mental health system with which the authors are familiar, ten percent of the personnel budget was held back by the department administrator and his middle-management team so that local government could have some discretionary money to use for nonmental health patronage positions.

Dr. Lewis discussed staffing under the political model in his large state department:

> . . . Those who do not understand the political model tend to be ineffective in that how one responds to political pressure will determine one's effectiveness. One should never sacrifice quality to political support, but one nevertheless responds to political requests in a cordial and realistic manner.
>
> Patronage is not useful in a large public mental health program. If used, it should only be at the lowest job level because at any other level, one is in danger of adversely affecting the organization. In my experience, affirmative action does not necessarily mean hiring indigenous people but rather obtaining quality minority representation.

Strengths and Weaknesses of the Political Model

The political model is most often found in public institutions. Its undeniable strength is its responsiveness to popular needs. Public organizations are more likely to offer services which are readily available, accessible and affordable. Consumers enjoy a wide array of service offerings. They may also find staff with whom they can be comfortable since personnel are often purposefully selected to reflect community values.

The issues of professionalism is an integral part of any discussion of the strengths and weaknesses of the political model. Shafritz, *et al.* contend that "personnel" is not really a profession in that those that enter the field have no standards of operation other than those associated with the political values of the agency and its patrons. Gouldner (1957) clarifies this orientation with his description of two types of social roles in organizations. First, there is the cosmopolitan role of the professional. The cosmopolitan has a commitment to specialized skills and to an external reference group as opposed to the employing organization and its members. Second, there is a local role usually filled by a non-professional who is highly loyal to the agency with little commitment to specialized skills or to an external reference group. In mental health settings, this local vs. cosmopolitan conflict reached its zenith in the early 1970's with the struggle between paraprofessionals and professionals in the community mental health movement. Paraprofessionals and their allies argued that skills are not as important as loyalties to the neighborhood and similarity of beliefs and values be-

tween a CMHC and the neighborhood. Professionals abhorred the lack of formal training and supervision in mental health workers with responsible clinical duties. To some during that era, CMHCs offered second-class treatment to those who could not afford private practitioners. To others, CMHCs offered clinical services which were for the first time accountable, available and relevant to the public.

Forces external to the political model organization may control its operation more than in any other model. This is due in part to the discretion exercised by public officials overseeing its operations. Public agencies are only too familiar with the consequences of satisfying the diverse demands of influential segments of society. Cutbacks in funding are typically lock step, having less to do with service requirements than the dynamics of the larger political system. Faddish programs may be initiated on the urgings of important persons. Even standards may be imposed by outside bodies. Ms. Vincent, the director of a rural CMHC with a budget of $360,000 and ten employees, commented on this issue:

> . . . The greatest impact on my center has been accrediting standards, particularly those of the state department of mental health. The center must be comprehensive and provide specific kinds of services in order to get state funding. Who I can hire is dependent on the priorities of the state for service delivery.

Compared to other models, political model organizations possess the tremendous advantage of ready responsiveness to public needs. By their nature, they attend to the expressed wishes of a pluralistic community. This advantage must be weighed, however, against the lack of internal control over operations and the resultant poorer quality of services offered.

The Standards Model

The standards model of organization assumes that there is a single best way of operating. Further, within any system there exists a finite range of acceptable functioning. At one end of the range are minimum standards of performance below which organizational actions are intolerable, while at the other end ideal standards are the goals to which all organizations aspire. Indicators are used to assess conformity to standards, the goal being one hundred percent conformity. Accordingly, staffing patterns emerge from striving to achieve conformity to ideal standards for personnel.

The oldest and most comprehensive set of staffing standards for mental health care is that of the Joint Commission on Accreditation of Hospitals (JCAH, 1983). The JCAH is a voluntary organization consisting of representatives from all the major health care fields. In an effort to police its own, this body has developed a set of standards based upon knowledge gained from consultants and inspections on site.

Recognizing the impact of the community mental health movement, the JCAH designed different standards for accreditation of community mental health pro-

grams (JCAH, 1979). These standards were particularly controversial because they were based on a "balanced service system" which entailed a radical idea—clients in need did not suffer from illness but were in a status or role deficit. Clients either did not know how to function or did not have the resources at hand to adapt to their environment. Consequently, staffing patterns did not reflect the preeminence of mental health professionals, but rather an assortment of professionals and nonprofessionals from mental health, education, welfare and other fields.

The American Psychological Association (APA) has developed standards for providers of psychological services. The APA also has specialty guidelines for the delivery of services by clinical, counseling, industrial/organizational and school psychologists (1983).

With the exception of the JCAH's standards for CMHCs, most staffing standards are qualitative. They provide guidelines in general terms about the type of staff needed for quality services. While they can be used to assess whether a potential exists for adequate service delivery, they are of little practical value in assisting the mental health administrator in day-to-day struggles with staffing. The standards do not address concrete concerns about number and type of staff, such as who and how many people do I hire to do the job?

In contrast, a variety of qualitatively-based standards of staffing have been developed both at the state and individual agency level. Some of these are the Scope Standards, the Ohio Personnel Simulator, and the Medicus Reporting System. The numbers and ratios used in the formula to derive staffing patterns are determined by expert judgments rather than outcome data. As an example, the staff and ratios of the JCAH "balanced service system" are based upon the author's conceptions of how an ideal service system should function rather than on staffing patterns of successful programs.

Mr. Bates, the head of the medium-sized CMHC, addresses this problem:

> . . . Accrediting standards are seen as a necessity in any industry. They are invaluable in measuring one's performance against another. Nonetheless, this is a badly abused concept in mental health. We tend to use either input variables or process variables rather than outcome variables in setting standards. How many beds are filled or how many office visits are tabulated in a day or a week are indicators of standards. What in actuality is being purchased is not a bed or an office visit, but a decrease in symptoms or a reduction in pain.

For the mental health administrator, quantitative standards can be used in a cookbook approach to recruiting and hiring. One simply plugs in the simulated program and compares current staffing patterns to those projected by the standards. Given that the administrator wants to have the service program modeled on the one for which he/she is deriving the staffing pattern, this is a relatively inexpensive and painless way of establishing present work force needs and planning for the future.

Every agency that employs professionals has implicit or explicit standards for

staffing. In some institutions, particularly hospitals and hospital-based CMHCs, professionals more formally express their ideas through professional organizations. The most frequent methods used by professional staff to control staffing are credentialing and privileging. These twin processes exist at most psychiatric hospitals and at a few CMHCs.

Credentialing is a review of an applicant's professional documents and personal references to establish qualifications for the position. A credentials committee is usually one of the most powerful organs of the hospital because it not only controls membership on the professional staff but also defines functional staff classifications. Privileging is the right to practice in a hospital, that right attaching itself to a position or specialty. Like credentialing, it is a powerful means of control over staffing since the decision is made by colleagues in the department in which privileges are sought. Dr. Coleman, the chief administrator of a psychiatry department in a large county hospital, criticizes this aspect of the standards model:

> . . . In medical settings, merit usually means credentialing. People who are excellent performers with a depth of knowledge and well-honed skills may not be rewarded justly because they do not have the credentials.

Mr. Bates, the director of the suburban CMHC, relies on the standards model for his staffing decisions:

> . . . My preference emanates from my decision about what functions should be performed. For example, in doing budgetary planning and assessing complaints, I use the rational model for staffing numbers. However, my philosophy of staffing and the staff mix are tied to the standards model. . . . Most rationally-based planning is "bottom-up" planning and, therefore, self-limiting. Alternatives are preordained by existing circumstances rather than by looking into the future. The use of the standards model is superior for it is "top-down" planning. It asks the question, "How many of what kinds of skills are needed?"

There are no more vehement critics than those addressing the standards model. *Ex cathedra* notions of *the* right way of functioning violate the rationalist's value of objectivity and the politician's value of egalitarian compromise. As an example, the "balanced service system" as a CMHC model met tremendous opposition, not because it lacked excellent concepts for service delivery, but because many administrators felt that they had to buy the whole package. Many of these administrators were willing to change some of their policies and procedures, but were not willing to accept its philosophical underpinnings. They felt that no one had the right to dictate mental health ideology to them. Thus, the standards model may be criticized for requiring the user to accept service systems based upon faith since there is no empirical evidence for their validity (Sheinfield & Weirich, 1981).

Of all the interviewees, Dr. Coleman adheres most closely to the standards model in staffing at his large county hospital:

> . . . I characterize my organization in terms of the standards model because its mission is based on standards. Since the primary services that are offered are emergency and inpatient, there is little leeway for trial and error. A precedent must exist for what is accepted, useful and proven. I find the notion of accrediting standards very useful. I prefer to function according to what is known. My only problem is with accrediting standards when they are based not on data but on an acceptance of a philosophy which is opposed to that data.

Another frequent criticism of the standards model has to do with blandness. Who could disagree with this American Psychological Association standard: "The composition of programs of a clinical psychological services unit are responsive to the needs of the persons or settings serviced."? The more vague and general the standards, the less teeth they have and the more they are subject to individual interpretation. The consequence is unreliable standards.

> . . . I see the standards model as an outgrowth of the rational model. When sensible people from a variety of professional areas agree on particular ways of doing things, they become the standards. The major problem with standards is that many are not defined properly.

The concept of minimum standards is also problematic. Not only does it reinforce mediocrity by accepting marginal compliance, but it is also difficult to conceptualize "minimally acceptable" to an ideal standard. It is as if someone can make the judgment that it is half perfect!

Professional standards also have had their share of critics. Interestingly, the majority of these focus on the motives of the professionals as opposed to the content of the standards *per se*. These critics point out that professional organizations are more or less guilds that function on behalf of professional interests and secondarily for the interest of patients (Szasz, 1874; Torrey, 1972; Gross, 1978).

Strengths and Weaknesses of the Standards Model

Organizations functioning under the standards model strive for the highest quality services. Compared to the other models, individual needs are more likely to be met because service delivery is the finest available. A number of accrediting bodies offer their own uniform, professionally-approved guidelines. Once an organization selects the guidelines to which it will adhere, it is a relatively simple task to pick and choose programs and staff.

The standards model can often be found in teaching hospitals and specialized and high-risk programs. In these situations, administrators must be conservative, staying with time-honored and widely-approved procedures. Students must train under the most rigorous standards of practice, while specialized and high-risk programs attempt to reduce their vulnerability to mistakes by adhering to stringent codes of treatment.

While this model limits exposure to poor practices, its disadvantage is that staff may be reluctant to change any accepted behavior despite compelling reasons to do so. The argument is often made that the standards model allows agen-

cies to be insensitive to local needs. Funding bodies sometimes impose their own standards as a condition of awarding a grant. Those standards may not be relevant to the program or the population which the agency serves. High-quality comprehensive services may be less important to a given population than a few well-sited, adequately staffed programs of pressing interest to them.

Another weakness of the standards model is that conflicts between professionals are occasionally disguised as conflicts over standards. The American Psychological Association and the Joint Commssion on Accreditation of Hospitals, for example, have long disagreed over credentialing and privileging of psychologists in psychiatric facilities. These "turf disputes" between psychologists and psychiatrists have been played out over the years in the form of whose standards will prevail in a particular setting.

The standards model is expensive. The finest programming and staff are so costly that administrators must settle for "minimum" acceptability. It is difficult to defend less than excellent services for the sake of not being able to afford them. Constantly striving for fiscally unattainable goals is frustrating and, ultimately, demoralizing for staff members. Cynicism and burnout are but two of the unfortunate consequences of such circumstances.

DECISION GUIDELINES FOR STAFFING IN THE THREE MODELS

Rational Model Guidelines

The rational model is most readily found in organizations with the clearest lines of authority, the private for-profit and private nonprofit agencies. Staffing decisions under this model are made with a well-articulated plan for staff levels in which rewards are adjusted accordingly. Resource allocation is determined by performance as well as need. Jobs are classified only when one can define a certain set of functions, and the responsibility of a job is commensurate with its authority. Adding new staff functions does not necessarily mean a need for new positions.

In terms of hiring, the rational model provides definite guidelines. Supervisors are best at predicting the success of an individual at a given job. One should try to employ individuals who have had direct experience at the given job because it is easier to shape a job than an individual. One should apply the "All things being equal" rule: When two candidates are equal in ability, employ the person who has previously performed a similar job successfully.

One of the characteristics of the rational model, merit selection, was unpopular with the interviewed administrators who view it as job protection rather than quality enhancement. Paper and pencil tests cannot assess many qualifications important to mental health jobs such as case management and supervision. Merit selection is more useful for purposes of retention and staff readjustments than

for hiring, and works best when the employer knows the candidate. In medical settings, it is often equated with credentialing.

Personnel ranking is often used by administrators, but the size of the organization determines its definition. In large organizations, both rank-in-person and rank-in-position are used, the latter for the less skilled jobs. In small organizations, rank-in-person prevails. Administrators require employees to fill a variety of functions. Paradoxically, in medium-sized agencies, rank-in-person may be viewed as a luxury. As one administrator put it, "We can't afford to have a farm team." In agencies dominated by credentialing requirements, higher level jobs are rank-in-position and mid-level jobs are rank-in-person.

Manpower forecasting is almost unanimously dismissed by the administrators. Among criticisms directed at it are (1) few useful methodologies, (2) frustrating because needs seldom match resources, (3) unrealistic with the lack of control of resources in the public sector, and (4) limited ability to plan for scarce manpower such as psychiatrists and nurses.

The concept of technical core was important to the administrators in that they felt that there is a cadre of individuals or a minimum set of skill requirements for a system to function adequately. Those individuals whose assignments may bear little relationship to the job title serve as strategic planners and troubleshooters. In small organizations, certain functions associated with professional roles are mandatory, for example, psychological testing with psychologists, or medication dispensing with nurses. The retention of these basic skills for the organization should never be compromised in staffing.

Political Model Guidelines

The political model is most frequently found in public organizations. Typically, these agencies have the least amount of administrative control since policy decisions are made by a publically-chosen governing body. The staffing process tends to value those employees who "make upper management look good". It is essential to staff programs to respond to the perceived needs of the public.

Some rules of thumb for staffing under the political model were suggested by the interviewees. One should not accept positions that one does not need since there is always a price attached to them. One should never employ a sponsored individual if it reduces quality of service. One should also use a revised version of the "All things being equal" rule: When two candidates are equal in ability, employ the sponsored individual.

Generally, patronage is dismissed by the administrators as out-moded. In the public sector, it is usually confined to the lowest job classifications.

Affirmative action was defined by the administrators as equality of opportunity to apply for a position. It is best carried out in the recruitment phase when an employer makes certain that all the available population for a job has been made aware of it. Non-job skills should be secondary in recruitment and selection. The process should not be limited to recruiting indigenous people. Yet,

affirmative action is difficult to carry out in rural or small agencies where incentives can be difficult to obtain.

The best argument for affirmative action is heterogeneity in that it increases communication among subgroups. Ironically, organizations that function according to a political model have difficulty in carrying out affirmative action. They tend toward homogeneity because power determines distribution of jobs.

Standards Model Guidelines

The standards model is most readily found in organizations with the greatest amount of professional control. Standards are useful for applying what is known and proven, and are particularly helpful in high-risk services where one can rely on that which is widely accepted.

Standards should be based on outcome measures. They are not useful when based on philosophy rather than data. In public settings, standards are often externally imposed.

Job positions are defined by tasks that can best fulfill the mission of the organization. Credentials are important to the knowledge base of the organization. It is acceptable to hire on skills as long as the employee is willing to continue his/her education. Under the standards model, the "All things being equal" rule is as follows: When two candidates are equal in ability, employ the person with similar values to your own.

Formulating a Staffing Strategy from a Models Framework

The purpose of this analysis has been to assist administrators in developing a staffing strategy for their organizations. A staffing strategy is simply a general plan for directing and integrating an organization's staffing activities. The first step is identifying an organization's predominant model of functioning. This allows the administrator to discover those issues or postures that clarify the organization's functioning.

Once the model is identified, the second step calls for the administrator to pinpoint problems and opportunities he/she faces in staffing in that particular organization. The third step, then, is to consider as wide a variety of options as possible and identify those that are suitable to the organization. Given the limited resources in any mental health organization, the administrator should be concerned with staffing effectively and efficiently.

The fourth step in a staffing strategy is determining how it can be implemented. An administrator is usually able to control directly only a few aspects of a situation. The solution is choosing priorities, which can be accomplished with more confidence after the organizational analysis. Let us suppose that an administrator has determined that his organization functions predominantly on the political mode. His staffing "mix" should include personnel with adequate skills who match the demographics of the community, volunteers from various community networks, and top-level personnel with political acumen. Understanding

that his organization survives and prospers by meeting political demands as well as mental health needs can greatly assist this administrator in making his particular staffing decisions.

Another administrator works in a hospital-based nonprofit clinic. In developing her staffing strategy, she determines that her clinic functions on a standards model, with hospital professionals and external accrediting bodies setting standards. Her staffing "mix" should focus on individuals with the credentials and skills accepted by her hospital's professional staff and the accrediting bodies.

Mixed Models

We have described the three models as pure types. In the real world, pure models seldom exist. Rather, we find mixed models in which one model predominates and elements of another are woven into the organizational pattern. A common situation involves a large political model organization with a rational model subunit, a Research and Evaluation Department. R & E runs on the assumption that decisions are data-based. The products of this department are used by an enlightened administrator to make sound decisions. The administrator then takes the R & E data to her political overseers to "sell" them on more public funding or different programming.

Another typical case is a community mental health center, publically-owned and funded, which has all the earmarks of a political model organization. The director respects standards and wants to be accredited by the Joint Commission on Accreditation of Hospitals. Three or four of his services are deficient and he is unable to hire the staff and document the comprehensiveness required by the JCAH. He goes to his appointed board, his elected county supervisors, and other influential leaders to argue that this center needs accreditation in order to get more third-party payments.

Still another illustration of a mixed model is a private teaching hospital. The chief has to assure high standards of training but she must also hold down her expenses in order to stay within her budget. Her solution is to require residents to fulfill house staff service obligations in return for supervision and salaries. The residents must conform to rationally-based regulations which take some judgments out of their hands, such as length of stay and financial intake requirements. Elements of both rational and standards models are intertwined in this hospital as it brings residents into the staff and teaches them to be doctors while they pay their own way.

A final example will suffice to demonstrate the variety of mixed models currently found in the mental health arena. A rational model for-profit community hospital initiates a health education department to address the needs of the public. The department is a loss leader, but does advertise the hospital to the community. Meanwhile, professional staff are sharply limited to admitting certain kinds of patients for particular treatments. This community hospital provides an outreach service, as would a political model organization, while admitting

patients in terms of ability to pay, an action more often identified with a rational model organization.

Evolving Models in the Late 1980s

Cost-cutting in the 1980's has led to the ascendency of the rational and political models in mental health organizations. Drastic reductions in federal support, more restrictive third-party benefits, and the success of private for-profit companies in segmenting specialty markets (e.g., short-term inpatient care, alcoholism and behavior modification) have all contributed to the financial squeeze. As public funding declines, public and private organizations will compete vigorously for limited dollars. The hardest hit will be organizations functioning under the standards model, the most expensive per service unit of all models. While administrators will continue to acknowledge their commitment to standards, the reality is that most organizations simply will not be able to afford the standards model in its purer sense.

We foresee funding bodies turning from enforcement of standards to education about cost-effectiveness. Since it is difficult at best to provide the finest service at any price, organizations will be as concerned with financial solvency as quality. The federal government is leading the way in educating the mental health sector with its DRGs, instituted as one way of curtailing spiraling costs. While the federal government has historically been instrumental in setting and maintaining national standards, it now promotes the concept of adequate care at reasonable rates, much to the chagrin of professional caregivers.

Competing for limited monies also means more attention to politics. Mixed models in which both rational and political elements are present will be increasingly common, particularly where public organizations must compete head-on with private for scarce dollars. In particular, we foresee public institutions incorporating elements of rational model for-profit businesses. As in the case of other government-funded activities, public agencies will be forced to learn the survival tactics of offering comparable specialty services for competitive rates while continuing to provide basic services. This has already begun to take place with many public organizations, particularly community health centers, offering EAPs, health enhancement packages and HMO-type services to business and the general public. Typically money losers, the basic services (such as after care and intermediate care) will be shaped by bargaining between influential constituency groups. Politics will remain in the fore in the basic services in terms of who is served by whom.

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