The Influence of State Regulatory Processes on Mental Health Programs

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THE VETERAN of the community mental health movement sees in the current national debate on the crisis in health services striking parallels to the concerns of the community mental health movement of the past decade. He also sees community mental health in a leadership role because it has already pioneered, refined, or at least articulated many features of current concern for general health services.

In the specific area of legislation and statutes, mental health is in a better position generally, State by State, than is the general health field. Most existing mental health statutes are more recent in origin than comparable statutes related to general health, as a result of legislative activities in the 1960s (*1*). Consequently, mental health laws are usually more progressive regarding comprehensiveness and accessibility of services, community base and citizen involvement, innovative contractual arrangements (such as between public and private sectors), and program evaluation and review. This position of statutory leadership, however, remains only a potential until existing statutes are clarified and implemented through practice, including the promulgation of appropriate regulations. Indeed, government regulation through administrative agencies is increasingly a significant characteristic of contemporary government. The demand for flexible and responsive mechanisms to meet rapidly changing needs has contributed to the growth of the regulatory mechanism.

In this paper, we explore the potential influence of the regulatory process on mental health programs and services. We also analyze the specific role of rules and regulations in the delivery of mental health services in order to define more clearly their potential role in solving the more general problems of delivering all human services.

We assume that regulations can both constrain abuses and promote more effective service delivery and utilization through explicit recognition of standards, allowable innovations (for example, service contracts with voluntary nonprofit agencies), and evaluation and review. In fact, we sug-

gest that variations in the quality of mental health services are strongly related to the variations in the rules and regulations among the various State and local governments. Although this latter assumption is not empirically testable in its present form, we will spell out more specific and limited propositions that can be derived from it when taken with additional considerations.

Because of the complexity of interacting professional, scientific, legal, statutory, financial, political, and social forces that influence the ultimate "quality" of mental health services, it is not easy to spell out simple "if X, then Y" hypotheses concerning the effect of regulations. Currently, there is little in the way of social and organizational theory that would lead to readily testable predictions relating regulations to other factors of interest in mental health. We present an initial set of hypotheses toward the development of such a theory. We state our views in the form of potentially testable hypotheses in order to make explicit the relationships we assume to exist and in turn to stimulate needed empirical research and development (*2*).

Significance of Regulations

The study of mental health regulations is closely tied to the specific concerns of community mental health professionals. More than 300 operating federally-sponsored public and voluntary community mental health centers and a growing number of proprietary (profit) clinics are now providing a variety of mental health services. These centers (profit and nonprofit) have a wide variety of administrative arrangements, programs, staffing combinations, and sources of program funding (*1*). Because of the increasingly pluralistic nature of such human service delivery mechanisms (*3*) and the recognized need for program performance evaluation (*4,5*), a realistic set of regulatory standards must be set forth for judging the operations and performance of all varieties of community mental health centers.

The reciprocal relationship between the development of regulations and the development of these centers must also be considered. Thus, regulations which preceded center development have determined or influenced their organizational structure and subsequent growth and effectiveness. Other statutes and regulations have been derived from new situations created by the existence and operation of community mental health centers. If it could be determined that certain organizational forms could better achieve certain mental health goals, or that particular mixes of public and private centers were optimal for certain broad policy goals, then it would be particularly valuable to understand how certain sets of statutes and regulations promote certain types of organizational form.

The critical impact of regulations on the community mental health center program of NIMH was thoroughly noted in a report by Ralph Nader's task force (*6*). The report indicates, for example, that initial regulations determining the population size for catchment areas may have arbitrarily constrained innovative practices, as well as the program's accessibility. Similarly, later regulations regarding citizen participation were judged by Nader's group to be overly vague and ineffective.

Besides the traditionally accepted method of program evaluation through followup research and statistical studies (*7,8*), regulations offer an additional tool for maintaining the quality of standards of professional practice and human service programs. For example, with the increasing development of proprietary mental health inpatient facilities, additional concern for the maintenance of quality standards of professional training and practices has been generated. In profit-making facilities there may be a temptation to hire inadequately trained staff at lower salaries. Furthermore, even with a professionally trained staff, proprietary facilities may provide services only to people who can afford either their fees or the third-party insurance premiums. Systemically, this exclusion process could thus drain off some of the effective social pressures needed to maintain adequate federally- and State-sponsored programs for the remaining population.

Regardless of sponsorship or the presence of a profit motive (even publicly-funded centers can become overly cost conscious at the expense of adequate programing), regulations can help to insure the delivery of services according to acceptable standards. Regulations, for example, can extend beyond traditional concerns for building and equipment standards and address such issues as personnel, programs, clientele, and interorganizational arrangements.

Finally, mental health regulations may serve a critical function in the larger context of new organizational arrangements for general health or

human services by helping to protect the mental health needs and interests of clients in the face of such new health arrangements. For example, the regulatory interpretation of broadly worded Federal or State statutes might require mental health coverage in prepaid group insurance policies. Although these new delivery models and proposals have value in their own right for the organization and financing of general health or human services, they could possibly lead to the loss of hard-won gains for the mental health delivery system.

The Regulatory Process

Before we turn to the relationships between the regulatory process and mental health programs, it is necessary to review some major features of the regulatory process as it applies to any substantive area and to point toward the potential of the regulatory process as a general tool for change.

On the Federal, State, or local level, regulation or rule making is a legislative or quasi-legislative function, delegated to the agency or department by the law-making body (*Arizona Grocery Co.* v. *Atchison Topeka & Santa Fe Railway*, 284 U.S. 370, 386 (1932)). The delegation of authority to make rules and regulations may be extremely explicit in the statute from which the agency derives its existence and responsibility; it may, however, be implicit in the nature of the law which the agency must implement (*9*). A rule or regulation can be defined as a determination "addressed to indicated but unnamed and unspecified persons or situations" (*10*) and as having general applicability and future effect. Moreover, a rule or regulation is often characterized as "having the force and effect of law" (*Yiatchos* v. *Yiatchos,* 376 U.S. 306, 309 (1964); *Accardi* v. *Shaughnessey,* 347 U.S. 260, 265 (1954)).

The enactment of a statute by a State legislature or by Congress constitutes concrete articulation of public policies. Because of the give-and-take nature of the legislative process, the resulting statute often consists of legitimate compromises, phrased in vague language and ambiguous concepts. This is particularly true when several individuals or groups are involved in the drafting process.

Moreover, a broad statute designed to comprehend an entire substantive area, such as sanitation, mental health, education, or taxation, could scarcely encompass the kinds of detail required for implementation or anticipate the myriad problems that arise from the passage of comprehensive legislation. The best legislation, in fact, may be that which is written with the least detail. Rules and regulations often function to provide the necessary details. The realization of broad social goals can thus be characterized as one of continuing refinement and specificity, moving from general public policy to legislation to regulation.

The rule-making function can be defined as "process." Although statutes may indeed be amended or repealed, such legislative change can be difficult to accomplish. Moreover, as indicated earlier, extensively detailed legislation is often an inappropriate and cumbersome means to deal with a complex and comprehensive substantive area. Regulations, on the other hand, are theoretically more flexible instruments; the procedures for adopting new regulations, or changing old ones, are designed to facilitate such change (*11*). Too often, however, rules and regulations, once adopted, are not flexible administrative tools but become as fossilized and permanent as statutes.

In exercising its rule-making responsibilities, a government agency is guided and proscribed by its statutory authorization. As we have suggested, the enabling legislation may specifically require certain kinds of regulations on certain subjects, indicating a clear legislative intent with regard to the scope of the regulations. Such delegated rule-making authority may be very broad or very narrow. Conversely, the statute may not mandate that regulations be promulgated. Nonetheless, regulations may be necessary to implement the statute.

The enabling legislation thus establishes the parameters of an agency's rule-making authority and the scope of the regulations themselves, that is, who is to do the regulating and who and what are to be regulated. However, rules and regulations formally adopted by an agency do not constitute the entirety of administrative control. Intradepartmental directives, agency "policies," traditional methods of procedure, and controls exercised by other agencies and departments at all levels of government can directly affect activities within an agency's purview. Moreover, other laws may establish or delimit the methods by which regulations are developed and promulgated and thus may affect an agency's rule-making authority.

Despite its somewhat "in-house" nature, the regulatory process is not necessarily shielded from public scrutiny and public participation. Such participation may be statutorily required in an admin-

istrative procedure act, may be initiated by the agency, or may be demanded by affected organizations or individuals.

It is important to recognize the variety of functions of rules and regulations, regardless of their substantive content. These functions are not mutually exclusive, and a single rule or regulation can be multifunctional. The broad functions are (*a*) establishment of minimum standards, (*b*) alteration of patterns of action, (*c*) uniformity and standardization of practices, (*d*) enforcement, (*e*) education, (*f*) hortatory expression of broad policy, (*g*) clarification and interpretation of statute, (*h*) interstitial action—"filling in gaps," (*i*) establishment of agency's authority over regulated parties, (*j*) minimal satisfaction of statutory requirements, (*k*) public relations, (*l*) subtle alteration of statutory language, and (*m*) prevention of abuses.

In addition to these functional roles, it is important to consider some "process" characteristics of regulations related to their promulgation, administration, and enforcement. Regulations may derive from Federal, State, county, or municipal enabling legislation. There may also be wide variations in the procedures for their promulgation, including the use of public hearings and reviews. The responsibility for monitoring and enforcement may be concentrated or shared among government agencies.

The target of regulations may be internal government units or programs of private, voluntary, and profitmaking organizations. Regulations may relate to consumers or providers of service, or both. The language of regulations may vary in the degree of imperativeness from "must" and "shall" to "should" or "may." Thus, regulations can serve a variety of purposes—restrictive, guiding or clarifying, educative, supportive or protective, promotive or encouraging. Regulations also vary in the consequences or penalties for noncompliance. Finally, regulations differ in their degree of flexibility and the frequency and means by which they are reviewed and revised, particularly in response to new information and feedback related to research or professional practices.

Classification of Regulations

For purposes of discussion, we developed the following categories of mental health regulations with some examples.

Physical facilities. These regulations are concerned with the minimal amount of space per client, fire and safety specifications, administrative authority for decisions regarding use of physical space, and facility modifications for physically handicapped clients.

Personnel. These regulations require particular staff-patient ratios and experiences or academic degrees for particular staff positions or tasks. (A major constraint has been imposed on the flexible use of manpower and on training by some regulations which preclude the use of nonprofessionals or nonphysicians in a variety of tasks.)

Administrative structure. In this category are regulations regarding the intraorganizational arrangements and the flow of information, funds, or services between subunits of a mental health agency and regulations affecting the interorganizational relationships between mental health and other service programs. For example, Federal regulations requiring catchment areas of 75,000 to 200,000 people have significantly influenced interactions within mental health programs, as well as between mental health programs and other caregiving agencies.

Client-processing policies. This category includes regulations defining eligibility for utilization of service programs and regulations regarding classification, diagnosis, hospitalization, and release of patients. For example, if a preventive program for adolescent "runaway" girls includes establishing a summer youth hostel, using inpatient community mental health center beds, would State regulations require such girls to be psychiatrically diagnosed and labeled as "mental patients?" Who is legally responsible for such adolescents? Is parental permission required for "treatment" of clients who are under the State's "adult age" limit?

Program content. Regulations in this category specify required services and their relationship to one another. Under the present NIMH guidelines for example, secondary and tertiary services are heavily emphasized while primary prevention activities receive attention only within the ambiguous category of consultation and education (*12*). In some instances regulations may require that after-care programs be specifically defined for anyone discharged from a State mental hospital.

Financing patterns. These regulations concern the relationship of Federal, State, and local funding and the possible sources of payments for services. Thus, medical care for some mental health

inpatients may be available through regulatory interpretation of title XIX of the Social Security Act. Similar to Federal matching programs, some State mental health centers require a matching component from county or local government. A related issue is the increasing trend among States to require equitable psychiatric coverage within medical insurance policies.

Citizen representation. These regulations define the role and powers of citizen groups in such matters as the formulation and approval of program policy, budgets, or services. For example, citizen boards may have regulatory authority to make specific contributions to the effective utilization of community resources for discharged hospital patients.

Data collection, information systems, and evaluation. In this category are regulations specifying the amount and type of information collected on clients or programs and regulations regarding program review or evaluation based on statistical information and case materials.

Regulations and Professional Attitudes

It is unlikely that many mental health professionals have an accurate understanding of the role of regulations and their potential value. Part of the difficulty in assessing the functional role and utility of regulatory processes on the quality of services delivered is the attitude of service professionals toward regulations. Because of inherent, and perhaps necessary, biases in training and subsequent professional practice, service-oriented professionals are likely to assume that regulations, by their nature, are simply restrictive bureaucratic rulings that only impede service delivery or make positive changes more difficult to achieve.

Although professionals may not have negative attitudes toward regulations addressed to building standards and sanitation, they have serious and reasonable concerns about those that might affect their own professional practices, administrative procedures, or treatment programs. Based on such reasoning, we believe that the attitudes of mental health professionals toward regulations in the various content categories vary according to how directly the regulations appear to affect them. Those regulations having a more direct effect will be more vigorously resisted.

Regulations and Mental Health Programs

The delivery of mental health services in the United States is traditionally a responsibility of State governments and usually constitutes a major investment of resources and a source of concern for State officials (*13*). In exercising its responsibilities, the State must maintain control of and accountability for delivery of services. The State can do this by providing the bulk of direct services through its own facilities. In such cases, because of the direct relationships and lines of authority (both administrative and legal) between the State mental health authority and its subdivisions which provide services, regulations are less likely to be written.

Alternatively, the State may decentralize delivery of services through lower levels of government (regional, county, metropolitan, or local) or through private (voluntary or profit) agencies. Because of the decentralized nature of these delivery systems, it is generally presumed that some State control is necessary through a regulatory mechanism. For example, under State-operated systems the employees will meet civil service standards, whereas under contract arrangements the State must insure quality of staff through administrative procedures of State licensure or regulation. Furthermore, with increasing decentralization comes increasing variation in funding and budgets, intake practices, and service programs. Although localized variations are always desirable, it is also necessary to establish minimum standards throughout the State for certain procedures and practices, such as eligibility for services. Given these considerations, we can assume that the volume and comprehensiveness of regulations will increase in proportion to the degree of decentralization and legal autonomy of the administrative systems that deliver services.

In a recent NIMH-supported study (*14*) conducted by the Stanford Research Institute, it was noted that among the 16 CMHC's studied, State financial support varied from 0 to 90 percent. Ten of the 14 States covered by the research had specific legislation providing for the State support of centers. Based on the wide variations among States regarding legislation for financial support, we further suggest that comprehensive fiscal regulation is likely to result from State legislation providing for financial support of centers. The existence of these regulations, in turn, will be associated with the continued viability of centers insofar as they allow or promote financial support through fees, third-party payments, service con-

tracts, local government support, or philanthropy. The Stanford study also revealed considerable variability among centers in terms of these other sources of funds.

Various legal forms for community mental health centers, as suggested by Curran (*1*), include a public agency, a voluntary nonprofit corporation, or, less frequently, a partnership or private psychiatric group practice. Each organizational form has advantages and disadvantages.

The disadvantages which tend to accompany public community mental health centers are the problem of obtaining adequate community representation and the inflexibility of administration and budgeting. The first problem is usually addressed by the appointment of advisory citizen groups. Such groups, however, frequently lack sufficient power or authority to affect center policies or operations.

As a partial solution to the problem of administrative inflexibility, Curran makes the following recommendation (*1a*):

> Efforts should be made to place legal controls in administrative regulations rather than in State statutes in the interest of greater flexibility. Administrative regulations have the full force and effect of law if enacted properly; yet they can also be changed relatively easily as experience warrants or conditions change.

A major advantage of public agencies is the likelihood of continued financial support. Public mental health agencies, however, must compete with other public systems (schools, courts, and others) for increasingly limited financial resources. For this reason and others related to the nature of bureaucracies, public mental health programs are expected to have less than adequate interorganizational relationships with these other public human service systems. This deficiency can be particularly true in such instances as when the mental health services of a State hospital must relate to a large city-operated school system or a county-operated court system (that is, cross-governmental interorganizational relationships).

The nonprofit voluntary agency, on the other hand, has a major advantage of flexibility and adaptability to changing conditions. Furthermore, inherent in its governance by a board of directors is the formal mechanism to insure more adequate community presentation. There are, however, additional possible relationships between the private agency and the public sphere. For example, voluntary agencies can become dependent on a variety of government financial supports. In fact, according to Curran (*1b*), "Few mental health centers are able to operate entirely without needing or desiring government funds for operation or research support. The reception of such funds carries with it certain legal implications." He goes on to document the legal opinion that, with the reception of Federal funds, private centers become quasi-public centers. In addition, many city and State governments have laws and regulations requiring certain reports and financial disclosures by agencies which receive charitable contributions. Such regulations define one more type of relationship between private agencies and the public sector (*1*).

Other relationships between private agencies and various levels of government can be established through individually negotiated contracts for direct services, research, and training, which in turn will be influenced by the regulations governing such contracts.

Since community or consumer representation is a less integral aspect of publicly operated mental health programs, their participation is likely to be required by formal statutes or regulations, or both. We may further expect that publicly operated centers will manifest more flexibility and innovation in those States that use regulations rather than specific statutory requirements. Flexible and changeable regulations, for example, may provide more administrative leeway to hire new career professionals whereas statutes restricting jobs to standard civil service requirements may be difficult to circumvent or change.

Regulations at the level of State or local government can help to promote or require interorganizational interactions, exchanges, or relationships that are critical to the development of mental health programs and services, for example, requiring representation on State or regional planning bodies such as health planning agencies. Based on such considerations, along with some of the issues related to the public-private interface mentioned earlier, we would predict that interorganizational relationships, both financial and nonfinancial, between mental health programs and publicly operated systems such as schools and courts will be less frequently recognized, required, or controlled by regulations when the mental health program is publicly rather than privately operated.

Furthermore, the quality and quantity of the general interorganizational relationships that a program has with other public, private, or quasi-public human service organizations will be positively related to the existence and content of regulations that address themselves to such relationships.

The role of regulations and their impact on the operation of mental health programs will vary considerably depending upon how explicit, enforceable, and comprehensive they are. Enforcement can be measured by such factors as the manpower and resources devoted to enforcement, number of complaints, or other incidents reflecting monitoring behaviors. Vague regulations, or explicit regulations that are not enforced, will have little influence on the development and day-to-day operation of services. Moreover, rules and regulations may well have a greater impact on the operations of programs when they are centrally administered by a single government agency which regularly monitors compliance. When regulatory authority is diffused among different government agencies, regulations are more likely to be contradictory and nonuniformly enforced.

Furthermore, because regulations are partly designed to prevent or restrain abuses, subtle conflicts of interests may arise when the same organization is responsible for both program development and regulatory compliance. One may frequently find organizational ambivalence or tension resulting from these dual responsibilities. Nevertheless, a significant dimension of any agency's regulatory authority lies in its capacity to be responsive to necessary changes and to enforce its rules and regulations when established. When programs are developed and administered by the same government agency that must monitor such programs, enforcement may be less stringent than in situations where development and regulation are separated.

Conclusion

With increasing concern for the delivery of health and mental health services must come greater awareness of the systemic relationships existing between regulations and the general quality of mental health programs. We have attempted to stimulate such awareness by reviewing the regulatory process and the explication of testable propositions relating regulations to mental health program financing, service organization and administration, community representation, interorganizational relationships, and professional practice and attitudes. We hope that empirical research will be conducted to further refine and support these hypotheses. Such research will help to further the quality of our organizational relationships, administrative practices, and professional training and services.

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