Dr. Broskowski's paper is not about leadership in mental health organizations, but about managerial technologies. These technologies are exercised within a value context established by leaders. Leadership involves the articulation of a vision, a mission toward which an organization is aimed. Values and missions make up the why of an organization; management provides the how.

The paper emphasizes two types of managerial technologies: (1) those necessary to articulate the leader's vision and guide the mental health organization toward those goals; and (2) those tools that are used in day-to-day maintenance that are essential for organizational survival with quality and dignity.

Strategic or long-range planning encompasses the first central technology. Strategic planning systems provide leaders with tools to identify the missions that their organizations will strive toward during the next 5, 10, or 20 years. In addition, planning tools can be used to disseminate these goals throughout the organization, and to check its progress toward those goals.

A second set of managerial technologies involves day-to-day organizational maintenance. Despite the cutbacks and rapid changes in recent years, the vast majority of human service organizations have “survived”; that is, they have not closed their doors. The key issue for which new managerial technologies are needed, according to Broskowski, is not organizational survival, but organizational survival with quality and dignity. To thrive requires that human service managers be able to draw on many technologies other than those that traditionally trained clinician-executives have learned. A successful mental health executive needs to be aware of and be able to access nontraditional skills which are outlined in the paper.

Changes in the environment have produced strong pressures for increased managerial sophistication. Increasing competition for paying clients has been generated by the rapidly growing proprietary mental health sector. Reductions in overall public funding for mental health services have created pressures for
effective management in the competition for scarce public sector dollars.

Recurring throughout the group discussions of Broskowski's paper were several questions, from which each group took different routes or placed different emphases. Three sets of questions provided a framework for group discussions:

1. Are clinician-executives really needed to run mental health organizations? Is there a value set that distinguishes mental health administration from, for example, fast food restaurant management, and that requires professional clinical training for top administrators?
2. Are there sets of organizational or environmental characteristics that demand different types of managerial expertise from mental health administrators?
3. There has been an apparent shift in national values toward a belief that health (and mental health) care is not a fundamental right of citizenship. Financial reimbursement mechanisms have created a de facto three-tiered delivery system. To responsibly manage mental health organizations, must we develop services with markedly differing levels of quality that relate to ability to pay?

**Group 1**

Much of the discussion in Group 1 focused on defining whether there is a unique role for the clinically trained executive. Some members of the group were concerned that an emphasis on generic management technologies might produce either a loss in clinical/humane values, or the application of inappropriate and/or ineffective quick fixes to clinical problems through the use of economic/fiscal technologies. A value clash was suspected between the values and measures of effectiveness of generic managers (e.g. M.B.A.'s) and clinician-executives. Mental health organizations may be similar to other firms that have highly trained professional staff whose work requires considerable autonomy with clients. Legal, architectural, and financial audit firms are typically managed by persons with advanced training in the core technologies of those industries.

Other group members expressed concern that emphasis on clinically trained managers represents an unexamined value position, an ideology. What, these group members asked, are the underpinnings of the faith? Do we still mean mental health administrators should be “fully trained clinicians” or are alternative training routes more desirable (e.g., tacking courses on core mental health technologies onto generic business administration training)? One group member remarked about the unexamined faith in the clinician-executive: “We often fall in love with our answers, rather than with our questions.”

It may be that the question of the clinician-executive is moot. It was pointed