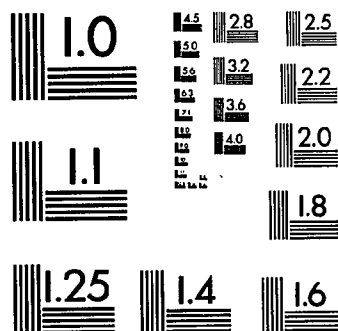


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CONSUMER PARTICIPATION IN THE MENTAL HEALTH FIELD

City University of New York

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CONSUMER PARTICIPATION IN THE
MENTAL HEALTH FIELD

by

Earl Foss

A dissertation submitted to the Graduate Faculty
in Social Welfare in partial fulfillment of the
requirements for the degree of Doctor of Social
Welfare, the City University of New York

1985

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EARL FOSS

1985

This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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Abstract

CONSUMER PARTICIPATION IN THE MENTAL HEALTH FIELD

by

Earl Foss

Adviser: Professor Michael Smith

This project is an exploratory study relating to one area of citizen participation - consumer participation in the mental health field. In many areas of the mental health field, consumer participation was mandated by Federal legislation in the form of establishing consumer advisory boards to the mental health facility.

Several authors have noted the need for formalized training of these boards to enable them to become more effective and to ensure social accountability of the mental health facility. The need for formalized training in such areas as the budget and budgetary processes, the organizational structure of the facility, group processes of the advisory board, program evaluation, and patient rights is noted by these authors.

The board training in this project was administered to a targeted population, an advisory board to

a community mental health center. The training content was formulated by a review of the literature on this topic, by a review of the board's past minutes, by discussion with the administration of the facility and by discussion with the board members as to their areas of concern and interest. Content analysis of their minutes was used to determine the effects of the training on a before-after basis. A comparison group of approximate equivalence was used in this project.

During the course of this project several limitations of training consumer advisory boards were learned. The infrequency of board meetings, the range of educational backgrounds of its members, conflicts between the power needs of the administration and the board, the ambiguous role of the board, and their lack of representativeness of their community constitute the main limitations. In spite of these limitations the board initiated more significant activities, the administration became more responsive to the board's requests and specific ideas to affect the organization were implemented by the board following training. This resulted in part due to a crisis but the training apparently was a contributing factor.

For these consumer advisory boards to fulfill their mandate, changes are necessary in the present system. At the federal level, the guidelines for citizen participation cannot be generic. Real power must be given

to these boards to achieve representative advisory boards. The schools which train professionals in the mental health field need to institute courses in the values of citizen participation and train students to recognize the potential benefits of such participation. These advisory boards also need to possess meaningful channels of communication with the organization it is to advise. Finally, board training needs to be conducted as a sequential learning process, not a series of independent sessions. A manual is provided in the appendix for training consumer advisory board members to a mental health facility.

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CHAPTER I

INTRODUCTION

"The fundamental characteristics of a society are evident in the values and assumptions through which it determines what is right and important for helping its citizens."¹

Contemporary views of citizen participation are rooted in classical democratic theory, emanating from the principles of Rousseau² and Locke³. In their analysis of the relationship between the State and the Individual, they emphasized the importance of the individual participation of citizens in the political decision making processes affecting their lives. This was a reaction against the prevailing monarchy with its centralized government and centralized decision making which had become divorced from the needs and values of its constituents. Their writings layed the theoretical framework for the French Revolution and the American Revolution. Centralized forms of government were viewed as the antithesis of participatory democracy.

Another aspect of this theory concerns the nature of man and his relationship to the State. Rousseau⁴ and Locke⁵ both wrote of the inherent rights of the individual which

were called "self-evident" in the American Constitution. They viewed man as not created to serve the will of the State but maintained the antithesis was true. The State was conceived as a creation of man whose primary role was to serve the collective good. Their writings stressed the basic rights of the individual which form the basis of our modern American democratic government, rights which included the means to participate in, and influence the decisions affecting the citizenry of the community.

The meaning of the term "citizen participation" has continued to fluctuate over the course of our history. The framers of our constitution ensured one form of citizen participation for all citizens, the right to elect public representatives. However, the term "citizen" did not include the American Indian, Blacks, or women at that time.

In modern times, generally, the term has come to mean some type of structured interaction between some local citizens group and a branch of government operating a specific program. For the purposes of this project, consumer participation will refer to a form of intervention, including a political process, in which issues are presented for public debate among consumers or their representatives prior to making an organizational decision. In a sense this usage represents the continuous struggle between centralized and decentralized forms of decision making and power.

In this usage of the term, two general purposes of citizen involvement arose, especially in the nineteen

sixties: (1) to influence policy decisions and the allocation of resources, (2) to share in the design, implementation, and monitoring of specific programs.⁶

In the nineteen sixties, due partly to the civil rights movement, the first purpose of citizen participation was translated into the term, "social reform" and the second purpose of citizen participation was translated into the term, "consumer control." Due to the climate of the time, the use of coercive tactics and confrontations occurred. In part, this may have resulted from the large growth of governmental programs with large bureaucratized staffs which lacked the structure as well as the desire to engage in a dialogue with citizen groups to determine their needs. It may have occurred in the human service institutions and among its professionals since, in many cases, they were alienated from the consumers and perceived them as a potential threat to their power. By its nature the first purpose of citizen involvement, influencing policy decisions and the allocation of resources, involves some degree of confrontation while the second purpose of citizen involvement, sharing in the design, implementation, and monitoring of specific programs potentially could be achieved by a dialogue between the professionals and the citizens.

Due to the political climate of the times, citizen participation was mandated into certain federal programs during the nineteen sixties and nineteen seventies. Most

notable of these programs were the antipoverty programs, Model Cities, the Community Development Block Grant programs, and certain programs in the health field.⁷

In general, during the nineteen eighties, there has been a weakening of citizen participation in many social programs. This is due, partly, to federal withdrawal from administration of many of these social programs on the local level as federal categorical programs were consolidated into block grants with few restrictions on how the money could be spent.

A major exemption to this trend were the provisions of Title XX of the Social Security Act. A period of public review was mandated before state plans for a variety of social service programs could be adopted. Also, a majority of the members of health planning agencies were required to be "consumers."⁸

In general, however, citizen participation during this period has not achieved major social reform. In a study by Roland L. Warren of fifty-four agencies in six cities, he found that despite the outward appearance of agency activity and change, the agencies were successful in resisting threats to their control of the delivery of services. Citizen proposals for significant change were modified into minor adjustments in existing procedures.⁹

Another factor which has limited success of citizen participation in achieving social reform is that many social issues are affected by macroeconomic variables outside of the control of local citizens or even the national

government. Changes in the country's trade balance, the federal deficit, interest rates, inflation, or deflation have a direct bearing on the level of poverty, the extent of unemployment, and the availability of federal, state, and local funds for social programs.

Peggy Wireman, in the Encyclopedia of Social Work, lists eight conditions conducive for successful citizen participation in a program.

These conditions are:

1. The group's mandate for participation must be clear, preferably based on congressional legislation
2. It must have sufficient organizational power to command the right to participate
3. It must be a legitimate, representative group
4. It must have ongoing access to information and decision makers while options are developed
5. It must have staff and technical resource persons who are accountable to it
6. Its members must be trained in methods of effective group action and must be knowledgeable about program technicalities
7. It must have effective input into the budget process of the program
8. It must be able to turn to the federal government or the courts if local officials deny its right to participate¹⁰

Seldom is this ideal reached in citizen participation. The degree to which citizen participation is successful, however, depends on the extent to which these conditions are achieved in any given program. They involve a commitment both on the part of the professionals and on the part of the citizenry. The focus of this disseration will be the sixth condition conducive to achieving successful citizen participation - training the members in methods of effective group action and knowledge about program technicalities. The other conditions also are important and necessary for achieving successful citizen participation in programs.

However, besides the goals of citizen participation, the means also have significance and value. Hilary Rose and Julia Hammer wrote in an article entitled, "Community Participation and Social Change,"

"The striving for participation and for the sharing of power are worldwide among students, the poor, the middle class, consumers, and producers. All seek opportunities to determine their own destinies. Participation in community groups can to some extent, be an expression of political life and of man's personal capacity to control his social context. The great practical value of participation, however, may in fact be social-psychological. For example, there is some evidence to suggest that people profoundly stigmatized for their poverty, their race or gender, by organizing themselves, and learning to struggle collectively

for social justice, can in fact delabel themselves."¹¹

This concept is further supported by the array of small group research in industrial psychology and sociology which indicates that when people participate directly in the decisions impinging upon their lives, they are more likely to feel a part of their community or organization.¹²

Both Farras (1969) and Puckett (1958) discovered that participation in decision making and planning by those not used to it increases performance and productivity.¹³

Guetzkow found that innovativeness in organizations is negatively related to hierarchial centralization of authority and is positively related to lack of programming and rule orientation.¹⁴ Similar studies show the direct relationship between productivity and worker satisfaction, and less hierarchial control and centralization.

Central to the concept of citizen participation is the educational function of the participatory process. To make meaningful choices between options available, one must be knowledgeable of these options and their consequences. The processes by which one achieves change must be known and the power and limitations of one's power within a community or organization must be understood or energies will be wasted, which can result in apathy. Only with substantive knowledge of the community or organization can one make discriminable evaluations of the effectiveness of the community or organization in meeting the will of the people. Power then must be shared. In an organization this involves

the sharing of power over such issues as policy formation and budgetary decision making. Those responsible for fulfilling the will of the people are then held accountable by an informed laity.

There exists several relevant theories to explain the dynamics of the interaction of people in centralized and decentralized forms of government and its institutions. The model chosen for this project involves viewing this interaction in terms of citizen participation. Other relevant approaches would consist of the Human Relations - Group Processes School of Thought, Systems Theory, different schools of thought concerning the sources and effects of power within an organization, organizational theories and various views of what constitutes the public interest. For the purposes of this project, the citizen participation model was chosen.

Nature of Project

This is an exploratory study relating to one area of citizen participation - consumer participation in the mental health field and the need to enhance this participation by developing an informed consumer group via an educational training program. The design of the training program selected was based upon a review of the literature which indicated core topics to be covered in training consumer advisory boards to mental health facilities and the training was based upon discussions with the board members as to their areas of concern and interest and upon discussion with

the administration of the facility as to their perceptions of what the training should encompass.

Based upon review of the literature the need for knowledge in the areas of the budget and budgetary processes, organizational decision making processes and group interactional processes seemed relevant. However, the extent of training in these areas is dependent on the stage of development of a particular board and their interest in these areas and the administration's interest in the board receiving such training. In this project, permission was obtained from both groups to present sessions on these topics. The group selected for this training required knowledge in these areas. The session on program evaluation was requested directly by the board in discussion with them on topic areas for presentation. The literature also states the need for such training. The session on "patient's rights" was requested directly by the board members during the training process. The administration of the facility selected played a passive role in the selection of topic areas.

Historical Background

Dating back to the early charity organization societies of the late nineteenth century, a bond was created between those with social problems in the community and the community's leaders. Through the use of the societies "friendly visitor", poor families would view the wealthy not as their enemies and, in turn, the wealthy would appreciate

the fortitude of the poor which would ensure their continued interest in the work of the charity organization. This would be expressed by serving on the boards of these societies and by giving some funds to the work of the organization.

The need for such an affiliation between the wealthy and the poor of a community did not arise solely out of philanthropic concerns. Following the Civil War and the influx of immigrants to the United States, cities were filled with poor people which created hygienic problems for all and created social unrest which could result in a revolutionary challenge to the existent social order.

The charity organization societies were a vehicle for the affluent to express their concern for the social problems of the community and through its friendly visitor program bring the two classes face to face and thereby diffuse rebellion.

By using the elite of the community on their board of directors, these agencies gained access to influence, funds, and prestige. At the same time, the focus of the agency's program related to viewing the individual deficiencies of its clients and the employment of techniques to strengthen the individual's inner resources. With such a philosophy the existing social order was not challenged. Nevertheless, this practice did involve citizens participating in the formation of policies for social programs and in the direct provision of service to people

with social problems.¹⁵

This view of social problems and their amelioration continued into the twentieth century. It helped foster the laissez-faire philosophy of the day and tended to minimize the environmental limitations which helped produce the social problems and helped prevent their amelioration. This approach to social problems was aided by the popularization of psychoanalysis in the nineteen twenties with its primary focus upon the inner dynamics of the individual, who was treated in a one to one relationship.

Two major events changed this focus. With the advent of the Great Depression of the thirties, the notion that social problems result from individual inadequacies became more difficult to support. Many of the unemployed who came to need food, housing, and medical assistance had held responsible positions and had viewed themselves and had been viewed by the community as adequate, responsible people. In effect, the Great Depression changed the focus from individual deficiencies to structural deficiencies of the society. This highlighted the need for a centralized system of intervention to aid the people of the country. This centralized system of intervention became the new role of the federal government.

The other major event which changed the view of social problems emanating from personal deficiencies was World War II. Treatment on a one to one basis had to be limited due to the large numbers of people requiring

psychiatric treatment with a short supply of trained personnel. Emphasis was placed on group therapy and the importance of environmental stress achieved greater emphasis under wartime conditions.

During this same period, the emerging field of Social and Community Psychiatry was gaining increased recognition. Blending concepts from psychiatry, sociology and anthropology, it stressed the importance of extrapsychic factors in personality development, in pathology, and in treatment. Its focus was upon community rather than institutional treatment. This would lead to the importance of interpersonal relationships in treatment and in the development of preventive paradigms.¹⁶ These concepts would ultimately find their expression in the development of the community mental health center, (C.M.H.C.). Following World War II greater emphasis was placed on viewing pathology from a public health frame of reference.

This movement reached its fastigium during the nineteen sixties. In 1961, the Ford Foundation coordinated programs for youth employment and education, while the Juvenile Delinquency and Youth Offenses Control Act pointed to the need to involve communities in a national analysis of their social problems (which questioned the effectiveness of existing health and welfare services).¹⁷

The President's Committee on Juvenile Delinquency noted the following problems of voluntary welfare programs in meeting the needs of the poor:

1. Many voluntary welfare programs were not reaching the poor
2. Those that were reaching the poor, many of their services were inappropriate
3. Services were fragmented and unrelated
4. Professionals did not have realistic understanding of the problems of the poor
5. Each specialty field was working independently of other services
6. There existed little or no participation of the poor in programs planned for them¹⁸

Under the Johnson Administration, these concepts were incorporated into the new social action programs such as the Youth Employment Act, the Economic Opportunity Act, the Community Action Program, Mobilization for Youth, and other similar social programs. The Economic Opportunity Act of 1964 called for the "maximum feasible participation" of the people affected by the program. This term was given an operational definition by the Green Amendment to the Economic Opportunity Act which stated that each local board shall have no more than 51 members, consisting of one-third of its public officials, one-third chose by a democratic selection procedure, and one-third members of other major interests in the community.¹⁹ The legislation creating the Community Action Programs mandated that one-third of the local boards consist of "the poor."²⁰ The focus of these programs was upon institutional changes involving the input

of those people affected by the programs.

With the development of the community mental health center, this same concept was adopted in the legislation. Each center was required to have a community advisory board whose "representatives must include broad representation of all elements of the community."²¹

Citizen participation in agency programs had come to mean the consumers of the service. Two major means of implementing citizen participation arose:

1. Representation on boards and advisory groups of mental health services
2. The use of indigenous workers within the mental health system

This study relates to the former, citizen participation on advisory boards of mental health centers.

Initial Problems

Several authors have noted problems associated with the concept of citizen advisory board participation. Initially, the presence of consumers on the advisory board of mental health facilities was mandated. The movement did not arise from a common philosophy between providers of service and the consumers of service. This created problems for both groups, resulting in several clashes between professionals and consumers over control of the local mental

health system. The mandate originally applied to federally funded Community Mental Health Centers under P.L. 88-164.²² This law required that those State agencies which had administrative jurisdiction over the local C.M.H.C.'s must establish State Advisory Councils to include "representatives of consumers of the services provided by such facilities."²³

The legislation neither defined the word "consumer" nor indicated the number of consumers required on each council. It was P.L. 88-749 (1964) which required that a majority of the council's members be consumers.²⁴ Community Mental Health Centers were also required to establish citizen advisory boards.²⁵ However, the meaning of the term "citizen" in this context was left nebulous. The only requirements mandated were "the representatives must include broad representation of all elements of the community" and 51% of the board members must be non providers of health care services.²² No operational definition was given to the term "broad representation." The ordinary definition of a consumer is one who uses a product. In this definition of consumer participation, this is neither mandated nor required. Born from a liberal philosophy, the regulations for consumer participation in community mental health centers were left vague and did not address the implications such responses would create, both for the provider of services and for the citizens of its community. Other social programs of the Johnson

Administration required similar input. It was hoped that this input would also extricate citizens, especially the poor, from feeling alienated towards the service providers. According to Yarmolinsky, this legislation was not intended for consumers to perceive themselves as a political force.²⁶ As always, power redistribution was seen as a threat. Due to the impetus of the times which called for citizen participation in services, the legislation mandated it; in principle, but the actual implementation was left vague. In the mental health field, the legislation did not state the roles and functions of the advisory board, did not establish criteria of effectiveness, and did not establish an ongoing monitoring process to ensure community representation on these boards.

In spite of this, many of the local citizens appointed, or who chose to serve on these boards, may have been genuinely interested in improving the services of the program, but lacked knowledge of the specialty to be effective in promoting change or lacked the skills necessary to navigate proposals through the organizational process.

The Need for Formalized Training

In order to aid these consumers to become more effective board members, several authors have recommended the establishment of formal training programs. Desdrin notes that consumer boards need training, and advocated it

as the best way to ensure accountability of the mental health facility. Her basis for this idea is the principle that mental health services should be responsive to community needs and the consumer must be trained to understand the operations of the mental health complex.²⁷

Brieland notes that training is necessary, for without it, the advisory board members will become "rubber stamps" or "window dressing" for the facility. He emphasizes the advice-giving role of a consumer board and believes that they should have policy-making power on issues affecting the community residents.²⁸

Besides the functions of advice-giving and policy-making, a community advisory board can also plan jointly with the administration of the Center to initiate, modify, or terminate programs of the community mental health center. The board also can achieve delegated authority in certain areas from the administration of the Center. These functions can range from having control over some aspects of the Center's decision making processes to merely receiving information from the administration of the program.

Zusman advocated consumer training since "only when the board understands agency problems and is qualified to evaluate the agency's work, can accountability occur in a valid and useful way."²⁹ Warren Papp noted that consumers on a board do not understand their role. "This leads to a call for their training." he concludes.³⁰ Chan and Passett

in their analysis of the citizen participation process conclude that since citizen advisory board members are less informed about mental health delivery systems, their problems, causes and solutions; there exists a need to educate these board members in order to achieve a redistribution of power within the mental health system.³¹ Koselski,³² Brieland³³, Bymers,³⁴ and Parker³⁵ make similar observations.

Even though there exists a wide consensus that formal training for consumer advisory boards is necessary for their effective functioning, there does not exist agreement as to what form, specifically, this training should encompass. Mario Caceres in his dissertation on Citizen Participation divides consumer advisory boards into three stages of development:

1. Internal Economy: creating the structure of the advisory board, occurring before or at the time of the facility's inauguration
2. External Knowledge: acquiring the necessary resources and information to achieve their goals as the facility becomes more professional
3. Negotiation: to make decisions and to influence decision makers, both within the organization and its suprasystem³⁶

He notes that the skills and knowledge base imparted to the board members varies as to their stage of development.

Parker advises that the training must remain flexible based upon the stage of development of the board, the nature of its individual members (their needs, educational background, and interests), and the organizational structure of the setting.³⁷

Although these concerns tend to obfuscate the contents of any training course, there does exist agreement among several authors as to what material should be included in a training program for a consumer advisory board.

Since the budget constitutes the main source of power within the organization, the processes of the budget, budget allocations, and priority decisions as reflected in budget expenditures need to be explained to the advisory board. In this way, their understanding of some of the dynamics of the organization will be enhanced. Accountability of the organization is also increased when the advisory board is knowledgeable of the organization's budget. No longer can requests be dealt with by the administration simply stating, "there is no money in the budget for that."

Several authors relate to the need for knowledge concerning the organizational structure of the facility and about the dynamics of organizational functioning. Treeker³⁸ and Wireman³⁹ both emphasize this point. The decision making processes within an organization, the information network

(both formal and informal), the effects of the suprasystem upon the organization, power distribution within an organization, and different explanatory theories of this distribution need to be explained to the advisory board. Especially important is the role and function of the advisory board as they relate to, influence, and are influenced by other parts of the organization. This leads to a clearer conceptualization of their role, functions, and activities.

In addition, several authors note that the board needs training in group processes, decision making within the group, and in problem solving techniques so that training sessions can have ongoing value (New⁴⁰, Wireman⁴¹, and Brieland⁴²).

Strategies of board training are also discussed in articles written on this subject. Greer, in her article on training board members for Health Planning Agencies, recommends the following strategies:

1. The focus should be limited to the immediate interests of the groups
2. Give them a sense of perspective of their board's interests and stage of development relative to other similar boards and their interests
3. Put people at ease
4. Use a common vocabulary
5. Remain flexible

6. Be realistic⁴³Previous Training

Several previous training sessions have been held with advisory board members. Caceres, in his dissertation, reports on their training at three Day Care Centers. In this example, the trainer was a social worker employed by the Center. The social worker limited her training to helping the board engage in socialization functions and in fund raising activities for the Center. Caceres found that the intervention of the social worker was a hindrance to participation as the social worker treated them as clients. In Caceres' redefinition of the social work role in this setting, he states, "the social worker should serve as a technical advisor, acting as enabler of the advisory board without interfering in their decisions or in their demands on the organization."⁴⁴

Parker reports on the training of advisory boards to neighborhood health centers. She approached key board members of several groups, relying on them to convey the results of the training to other members of their respective boards. The workshop method of training was used, employing role playing techniques. The focus was upon developing problem solving techniques among the group and in defining their role relationship to the Center. The following results were reported to her by the group members:

1. The self-confidence of the group increased
2. They developed new confidence as to their

legitimacy

3. An increased ability to work together⁴⁵

In the public health field, similar efforts have been undertaken. In New York City, the Health Systems Agency conducted open meetings in each borough to inform citizens and providers about such public health issues as credentialing, certification, licensure, and reimbursement controls. This occurred in the Fall of 1979. A series of five lectures were presented in each borough.⁴⁶

Under Ghetto Medicine, a city, state program to subsidize the deficits of municipal hospitals located in ghetto areas, training programs were developed "with objectives such as, providing information on particular types of programs, as well as, circling in on the development of group participation skills, planning and management expertise."⁴⁶ In New York City, the Community Health Institute (C.H.I.) developed such a program for the Advisory Committee of a local general hospital. The hypothesis of this training program was that the educational intervention program would have an impact on the activities of the hospital. Its purpose was to develop an informed leadership and to develop effective cooperation between health professionals and consumers. The immediate objectives of the program were:

1. To promote a positive partnership between the health providers and the health consumers

2. To provide skills at participation in, and influencing policy, plans and programs at all levels
3. To facilitate the recognition and acceptance by providers of the validity and legitimate responsibility of the new participants

The program assumed that if the training promoted consumer input, then vehicles other than hospital administrative action are possible to change the delivery system. Systems theory was used to support the rational of this assumption.

The training sessions included both the consumer board and the professional staff of the program. Five sessions were held of approximately two hours each. They were divided into the following main topic headings:

- I. Orientation
- II. Comprehensive and Preventive Care
- III. Hospital Decision Making and Hospital Economics
- IV. National Health Insurance
- V. Summary

Content Analysis of the board's minutes (before and after the training program) was used to assess the quality and the quantity of change. Particular attention was focused on whether these changes in the minutes were more

substantive and less procedural. Individual interviews with each member of the board, the professional staff in attendance at the training sessions, and hospital administration were also held. However, the trainers decided to place greater importance on the content analysis of the group's minutes. They felt that the interviews would be contaminated by the group making laudatory remarks directly to them. In addition, a content analysis (before and after the training sessions) could give a comparative analysis as opposed to the case study method.

The sessions led to a dramatic increase in community activity and consumer input. The consumers felt that they had received increased knowledge, higher group participation, sophistication, and the ability to work together. Other C.H.I. training sessions report similar results. Content analysis indicated an increase from 61 to 105 consumer inputs (communication with the director of the facility about program operations) into the program. Administrative action on these inputs increased from 22 to 37 after training, based upon content analysis of their minutes.⁴⁷

Major Issues in Consumer Participation

One of the main limitations of this approach is the extent to which the consumer advisory board is representative of its community and the extent to which it has inputs into community groups. Potentially, this is the

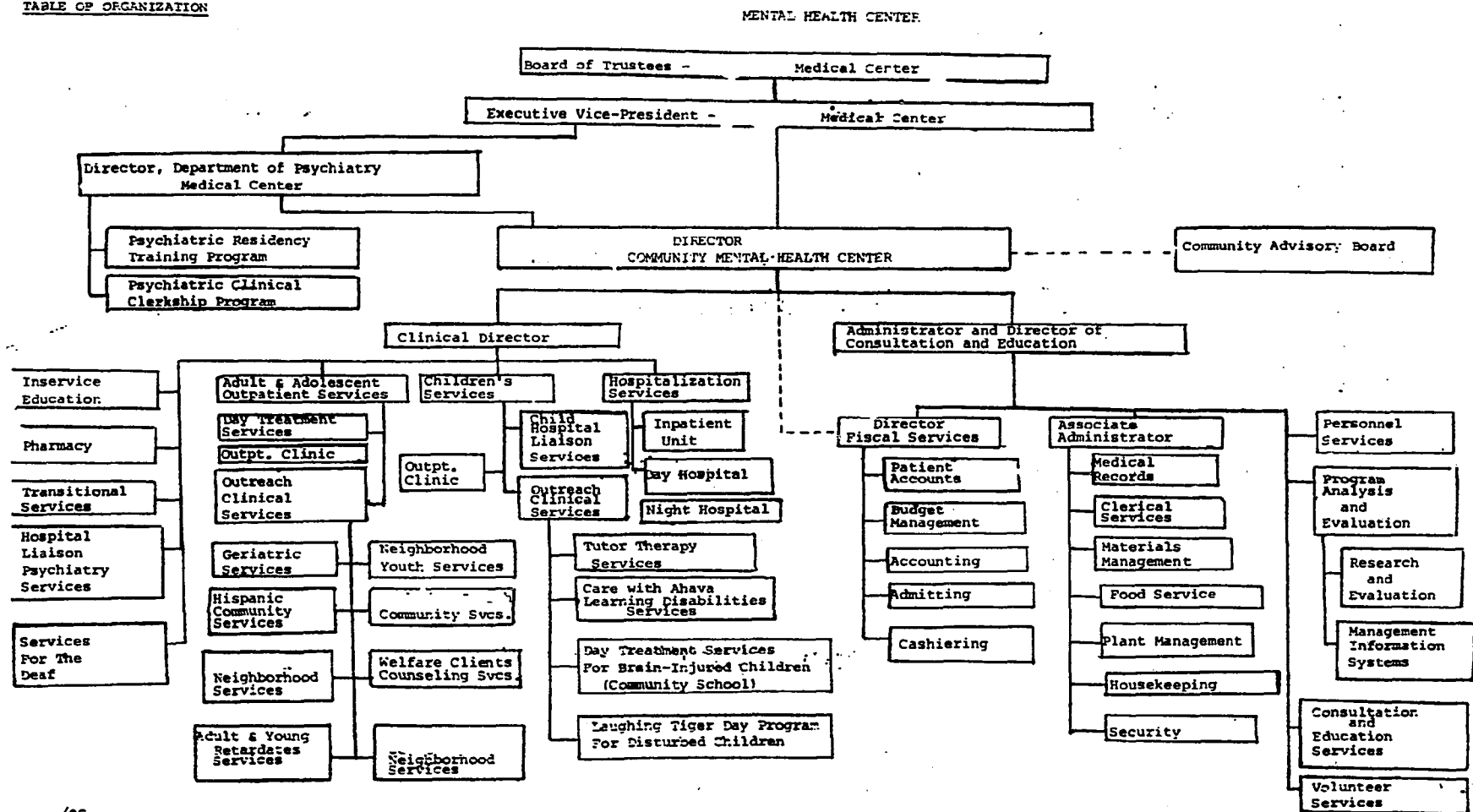
main source of power for a community advisory board.

Usually, individual board members do not serve as representatives of specific community organizations.⁴⁸

Previous studies in this area have indicated that local consumer advisory boards of mental health facilities are not truly representative of their communities and have limited, if any, input into various local civic and political groups.⁴⁹ It is postulated that with increased ability of the board to influence the local civic groups, the board will exert greater influence upon the mental health center.

Other limitations relate to the structure and processes of a community mental health center's organizational system. The center's formal information network is based upon the hierarchy of the organization. Usually, what constitutes "issues" and "priorities" are established elsewhere within the system. Below is an example of a table of organization of a community mental health center.

TABLE OF ORGANIZATION



The flow of formal information proceeds through established channels of the organization. Involving the consumer board in these issues and priorities can be dysfunctional for administrative efficiency, as involvement increases problems of communication, is time consuming, and complicates the authority structure of the organization. The issues presented by the administration to the advisory board may be defined in managerial and bureaucratic needs of the organization rather than in terms of the board's needs.

In addition, professional language is interpreted to them often masking the values contained in the statements. The lay person can be intimidated by this professional language and passively accept the professional's position on a matter. In effect, then, the professional may become the expert on all matters.

Within the organization, the board's resources are frequently fragmented, leaving the board confused as to the method of negotiating proposals through the labyrinth of the organization. As can be seen on the table of organization of a community mental health center, what channels to follow to propose issues, fulfill proper procedures, and how to gain formal acceptance of a proposal becomes confusing in a large bureaucratic organization.

Frequently, consumer advisory boards have little, if any, contact with the suprasystem of the organization. How similar mental health center's function, the nature of their activities, how they have dealt with various problems, how

they relate to their consumer advisory boards and regulatory agencies can be unknown to them as residents of one community mental health center.

Power also is new to them and they have to learn the parameters of this power. Citizen participation is one value affecting the decision making processes within a community or organization. Its antithesis value, leadership also is constantly operative. Due to either citizen apathy or due to the complexity of the organization, forces within an organization strive towards centralized decision making which can help ensure conformity, simplicity, and speed in the decision making processes of an organization. Situations may arise within an organization that compel this value. Another competing value to citizen participation is the role of the "expert." Under this model, programmatic alternatives are decided upon the basis of rational merit rather than politics or majority rule, theoretically. However, this rational model is based on values which in time may run counter to the will of the people. Hence, the dialectic nature of these competing values will assert themselves and contain the seeds of their own undoing.

Since the advent of legislation mandating consumer advisory boards, some providers have used a variety of techniques to curtail their power. Containment, co-optation, codetermination and other delaying tactics have been the main strategies employed.⁵⁰ Hence, training is

necessary for the board to recognize these strategies, how to cope with them and to realize what they can and cannot accomplish.

Values and Assumptions

Potentially, a consumer advisory board has certain value both to the providers and to the citizens of the community. The chief values of a community advisory board are:

1. Potentially, the Center's services can be enhanced by the participation of non professionals in an advisory role
2. It serves as a liaison between the community and the Center. From the community, the board can learn their needs and grievances and transmit this information to the Center, resulting in less alienation
3. The board can help interpret the Center's program to the community so that the Center's goals, direction, and problems are understood
4. The board is a potential political action body and can help develop community support for a program
5. It is a potential means of recruiting volunteers
6. It can be a major method of protecting citizen rights in the program and of

setting obligations on the providers

7. A community advisory board can help build a sense of community and a positive partnership between consumers and providers
8. It acts as a source of referrals to the agency
9. The board can help make the program more responsive to the needs of the community

These potential values are based on certain assumptions concerning a community advisory board. The major assumptions of this study concerning the need for a formalized training program for the board are:

1. Based on democratic theory, society should allow its citizens to participate in those institutions, processes, and forces affecting their lives and the lives of other people in their community
2. In the mental health area, services are enhanced by the participation of non professionals in the advisory role
3. Community advisory boards should be given the opportunity to receive the knowledge and skills necessary for effective participation
4. Efforts should be undertaken to enhance the ability of the consumer advisory board to function to their maximum potential

5. The consumers or potential consumers of a service desire an organizational provider mechanism which functions to its maximum capacity in the delivery of services to them
6. Consumer education of an advisory board is a desirable end. A commendation flowing from this value is that consumers should receive adequate information to make informed choices over those issues regulated to them as members of a consumer advisory board

In summary, based on classical democratic theory, it is assumed that citizens should participate in those decisions affecting their lives and community. In the mental health field, this concept has been translated, in part, in the development of local consumer advisory boards to mental health clinics. Initially, these local boards were mandated, resulting in resistance by the providers of services, perhaps out of an initial fear that an ochlocracy would develop. Several authors have noted that formalized training is necessary to help these boards function more effectively, to ensure accountability, to understand their role, and to fulfill their mandate. The literature is replete - both stating the need for and necessary content areas of the training. These content areas will be used in the training workshops involving the participation of the

advisory board, the administration, and the researcher. In Chapter II, concepts relating to citizen participation within the context of democratic theory, organizational theory, and bureaucratic theory will be discussed. Based on these considerations, the objectives of this study will be stated.

Chapter III will discuss the characteristics of the program setting and how those characteristics affected the intervention strategy employed. It will also serve as a key component as to the limitations of this type of intervention strategy.

Chapter IV will contain a discussion of the research design which will include a description of the training programs, limitations of the training based upon characteristics of the board, and the follow-up study.

In Chapter V the analysis of the data will be described. This includes the use of an experimental and comparison group before and after the training sessions.

Chapter VI will consist of a summary, conclusion and recommendations for further training of board members based upon this experience.

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CHAPTER II

CONCEPTS RELEVANT TO CITIZEN PARTICIPATION

This chapter examines some concepts which are central to this study. Since this study occurred at a Community Mental Health Center (C.M.H.C.), the concept of "community" as it relates to this setting will be discussed. Other key terms are the concept of power as it relates to an advisory board and the concept of citizen participation. This latter term will be explored within the framework of democratic theory, bureaucratic theory, and organizational theory. The other key term involved in this study is the meaning of "representative" as it relates to advisory board membership. Finally, these terms and their usage within the context of this study will be related to the objectives of the study.

The word "community" is an abstract concept with multiple meanings and connotations. This tends to make the word easily misunderstood. Since the word relates to diverse phenomena and can be applied in a variety of situations, it is necessary to subject the word to critical analysis.

Sociologists since Comte and philosophers since Plato have grappled with the meaning of the word,

"community." One useful way of defining community is based upon Tönnies' typology. In his writings he divided meanings of the word into two major categories. One type of community was called, gemeinschaft and the other major type, gesellschaft.

A gemeinschaft community can be likened to an extended family. An implicit bond relates person to person in such a community. This type of "community" is held together by a set of common rules, affection, respect, mutual dependence, and a sense of status hierarchy, usually based upon age. Its societal institutions reflect the values and customs of its citizenry. Formal values of relationship are minimal as the roles of the community's members are set by the tradition and cultural expectations of the group.

Today, this type of community is rare in the United States. Where it is still present, it is maintained by a radical provincialism. They resist acculturation. The Amish settlements of Pennsylvania is an example.

Due largely to the urbanization of America, today's dominant type of community is Tönnies' second major classification of the word, the gesellschaft community. In this type of community, relations between people are based primarily on formal rules and regulations. Affection and dependency is confined to the immediate family members. People come together through formal organizations. Law and

regulations determine, to a large extent, interpersonal interaction. Relationships are departmentalized and usually based upon functional needs.¹

Although the reality of today's dominant type of community is gesellschaft, within this structure elements of the gemeinschaft community exists, namely the family. The two categories are not mutually exclusive. This has implications for planning community mental health services.

As amended, the Community Mental Health Center Act created individual geographic areas for each community mental health center.² These assigned areas of responsibility, called "catchment areas" had as their purpose to ensure accountability for patient care (each patient of the facility had to reside within its catchment area) and to prevent funding for competing mental health centers. Each area was to comprise populations for no fewer than 75,000 people and no more than 200,000 people³.

This Federal legislation, creating "catchment areas" relates to the gesellschaft type community. It is a "where" community defined by street addresses and general demography. To think of this "community", that is "catchment area", as an area of shared beliefs, common problems and a homogeneous population is a neology.

In practice, the use of catchment areas created serious problems both for the patients of the C.M.H.C. and their respective community advisory boards. Connery found in his study, for instance, that the catchment areas came to

be defined by the large medical centers which sponsored C.M.H.C. components to their program.⁴

He noted that these medical centers were interested in developing a community mental health center component as an outgrowth of their own programmatic structures and to increase their capacity, influence, and power. Hence, patient care and patient resources were determined by the organizational network of the sponsoring medical complex, not necessarily based upon factors relating to the quality of patient care, such as access to services based upon transportational facilities, cultural, racial, or class preferences. It also created problems for advisory board membership since the various groups or organizations which they might represent had different boundaries of membership and influence than the boundaries of the catchment area. This would serve to weaken the effectiveness and power of the community representatives on these advisory boards. In the end, the C.M.H.C.'s "community" became what the legislation defined as a "catchment area." It was not necessarily contiguous with the political boundaries, geographic boundaries, or any other established subdivisions within the area. This produced fragmentation of board membership and weakness in the board's ability to relate to its representative body. In fact, the lack of clarity around the concept of "community" as mandated in the C.M.H.C. act and its amendments could create diverse means for the medical center

to utilize input from the community.

Desirable changes also have occurred as a result of the federal regulations which assigned catchment area responsibility for community mental health centers. It can lead to general improvement in the distribution of services and some aspects of the quality of services offered to the public. In most instances, it meant that mental health services would be located closer to the patient's home than previously. This represented an improvement over the state hospital districts which frequently encompassed hundreds of miles. The catchment area concept also encouraged continuity of care in that a patient can return repeatedly to the same agency for treatment despite changes in diagnosis, severity of illness, age, or other factors which traditionally led to transfer to other psychiatric facilities.

Since the maximum population of each catchment area consisted of 200,000, this increased accountability to the "community" it served.

Epidemiologic studies are made possible since service is defined to a specific area. Evaluation of preventive efforts becomes easier since these efforts are focused on a defined population. Gaps in the range of services also becomes obvious with a defined population.

Planning for new or additional services is easier since the necessary epidemiologic and evaluative studies can be done and the projected service needs of a particular

population can be estimated.

Finally, the catchment area regulations have served to encourage relatively smaller mental care systems than existed under most state hospital systems. By virtue of this smallness, they are likely to be more therapeutic than large state hospitals. The dehumanizing mass processing which often takes place under the auspices of a large, highly organized bureaucracy is less likely to occur.

The effects of some aspects of catchment area reorganization depend upon the local situation. For example, division into catchment areas may result in reinstitution of racially or socioeconomically segregated service facilities where major efforts have been made in the past to eliminate this segregation. Catchment area boundaries may be deliberately or unintentionally drawn so that they produce this result. In some cases, because of the size of a minority group in a community, it may be necessary to design a catchment area which will be composed completely or almost completely of minority group members. When this happens, it then becomes easier for pressures from various groups to lead to unfair or uneven allocation of resources. Where previously, for example, mental health services were budgeted on a statewide basis and all state residents had available the same service, the state mental hospital; it now becomes easier to provide one kind of service for middle class persons in one catchment area and another kind of service for lower class persons in a

neighboring area.

Catchment area boundaries may also divide natural communities and lead to fragmentation of a community rather than unification. This fragmentation may make it difficult for the community mental health centers to provide a good service and may also sever ties of political support and professional accountability which had developed between a mental health agency and locally elected representatives. In many cases, catchment area boundaries have been drawn without consideration for the boundaries of political districts.⁵ The mental health center must then relate to a number of legislators and each legislator must relate to more than one mental health center. This becomes an unnecessarily complicated process.

In summary, the introduction of the "catchment area" provision to the establishment of community mental health centers contains both strengths and weaknesses. The relative importance of these depends highly upon local population characteristics, geographic characteristics, and economic and political considerations.

Power

Although the term "power" is a neutral one, it is frequently given negative connotations. It is obtained in any situation by action and usually occurs within a social context. Within the context of this study the manifestation (its ability to effect or oppose change) will be confined to its use in a community, a community mental health center,

and its citizen advisory board.

There exists two major schools of thought concerning the use of power and sources of power within a community which are relevant to this study. Although different authors refer to these schools of thought by different names, here they will be referred to as the elitist or social stratification - power structure school of thought and the egalitarian or pluralist school of thought.

The elitist school of thought maintains that power within a community is always in the hands of an elite group who do not allow for any real (meaningful) sharing of power. This was the basis for Floyd Hunter's examination of power in Atlanta, made famous in his book, Community Power Structure. The division of power had been worked out between a select group of people who prevented other groups from sharing this power. According to his model, consumer participation is a myth.⁶ The leaders made decisions to maintain their own positions and feared any sway in the balance of power.⁷ According to this model, a community's mental health advisory board would be used by the administration of the C.M.H.C. to engage in such activities as fund raising, providing public support for its policies, and for creating public images of its programs.

The egalitarian model is a more dynamic and open one. Unlike the previous model, the egalitarians do not view power as concentrated in the hands of a few people who rule a community. Rather, they view power as more issue

related, receiving inputs from many diverse areas. Different groups are constantly vying for power and appeal to the people for support. This view is supported by Robert Dahl and his colleagues at Yale who found in Chicago, "that decisions were not made by a small group of the rich, but by many from diverse areas."⁸ Decisions frequently are made in a non rational manner and public reaction to these decisions becomes a factor in the decision making process. His main thesis was that in a polyarchal democracy one finds, "a political system in which all active and legitimate groups in the population can make themselves heard at some crucial stage in the process of decision."⁹

In summary, this position views power in a community as an open system in which different interest groups must reciprocate with other groups to gain support for those issues of concern to them and eventually are accountable to the general citizenry of the community who can withdraw sanctions from them.

Under such a model, the activities of a consumer advisory board to a mental health center would consist of bringing to the administration of the Center the interests of the special interest groups which they represent. Bargaining and trade offs would occur between the two groups. The extent of such activity, of course, would be dependent on local community concern over mental health issues and would be dependent on whether interested groups in the community have representation on the local advisory

board of the mental health center.

Citizen Participation

"He who has the power to take part in the deliberative or judicial administration of any state is said by us to be a citizen of that state."

Aristotle, Politics, Book Three, Chapter One

The above definition of "citizen" is adequate for the purposes of this study and has withstood the test of time. To be a citizen implies that one has a relationship in two directions with the greater social network. One has responsibilities to perform certain actions which make up the role definition of citizen. The reciprocal, obligatory feedback of this on the part of the community or system is that the citizen has rights which he may turn into "demands." A citizen is one who participates in the decision making process. This participation can take a direct form as in the traditional New England town meetings or take the form of representative participation.

For the purposes of this study, the term "citizen participation" is confined to the consumer board members of a community mental health center's advisory board. These boards were established as the vehicle of citizen participation by P.L. 94-63. However, several limitations were placed on board membership.

By consumer membership, the National Institute of Mental Health stated "the representatives must include broad representation of all elements of the community." It

also stated that 50% of its members must be non providers of health care services.¹⁰ A review of the Federal Register does not reveal any additions or changes in that definition. The term "broad representation" was left unclear nor was any mechanism established to monitor these requirements.

Theoretically, a C.M.H.C. could install in-laws or other distant relatives on these boards or they could install representatives of firms which contracted with the C.M.H.C. In either case, these people would represent vested interest groups which was not the intent of the N.I.M.H.'s policy.

The board members also could include former patients of the facility. The patients or board members were required to reside in the "catchment" area of the C.M.H.C.¹¹

Since these board members are "representatives" of the center's catchment area, the issue arises, "what does a representative represent?" The term is frequently misused and requires clarification. Alexander and McCann pointed out two possible meanings. One meaning of the term relates to a socio-political idea wherein the representative is functioning as an authorized representative of some group with legitimate authority to speak and vote on behalf of the parent group. The representative then reports back to the group he represents and receives sanction from that body. This use of the term "representative" provides for the true democratic delegation of responsibility and can result in the parent group's visibility and accountability on the advisory board.

A second use of the term relates to a statistical frame of reference. Here, the representative typifies some group within the community such as a "housewife" or a "factory worker." In this use of the term, the "representative" is not accountable to any group and possesses no clear channels of communication to the group he typifies. He also does not have the authority to speak for that group. This is a weaker use of the term "representative" and can result in distorted views among the other board members. In either case, the legislation did not consider this possibility in the framing of requirements for consumer board membership.

A second consideration in the use of the term "citizen participation" within the context of this study relates to the level of board participation. As stated, the egalitarian model which views participation as a multi-variate process will be used in this study. The level of participation will be viewed from the model developed by Brager and Specht which, for the purposes of this study, seems the most efficient and clearest model to reflect the board's levels of participation. The model divides the level of participation according to the following paradigm:

<u>Degree</u>	<u>Participant's Action</u>
Low	None
	Receives Information
	Is Consulted

Advises

Plans Jointly

High

Has Delegated Authority

The use of this model will be reflected in the pre questionnaire given to the board members (to reflect their pre conceived levels of participation) and will be reflected in the descriptive analysis of the author's perception of the board's level of participation.

Participation in the Context

Of Democratic Theory

Antedating modern nationalism, Rousseau wrote extensively, from a theoretical framework, about participatory democracy. In his writings he stressed the importance of the individual participation of citizens in political decision making which transcended the institutional arrangements of the decision making process. He proposed also that participation involves a psychological impact on the individual, facilitating collective decisions and produces feelings of "community" among participants.¹⁴

Rousseau conceived of participation as a self-sustaining process in that, once it is structured and put into action, the more an individual participates, the more competent he becomes to do so. Central in his theory is the educational function of the participatory process. The individual becomes aware that he has to consider his own private concerns but that, if he is to be involved in the democratic process, he must consider others also and earn

their cooperation.¹⁵

Rousseau, therefore, demonstrates the importance of the participatory process by integrating the authority structure of institutions with the psychological qualities of individuals.

Cole, writing within the Industrial Era, bases his theory, in part on Rousseau's postulates, but proposes that it is will, and not force, that is the basis of social and political organizations. He treats the idea of participation within the context of self-expression, and this self-expression entails self-government. Therefore, man's cooperation makes possible the satisfaction of his needs.¹⁶

Thus, for Cole as for Rousseau, the concept of participation is the main tenet of political theory. Cole's formulation is based on a theory of association which holds that a group remains together by the will of its members.¹⁷ Through these associations, individuals learn the democratic method. This learning of democracy takes place in small units at the local level (in which an essential feature is the concept of total equality of status, such that everyone can be a decision maker) and is then projected to the national level.¹⁸

Whereas classical democracy emphasizes the participatory process, modern theories of democracy de-emphasize participation in favor of representative government.

This is viewed as a realistic necessity due to the size of today's governments. It would be impossible to have direct and constant participation by the general population. To be realistic and viable, modern democratic theory, as embodied in the concept of representative government, has to deal with issues based on the experience of today's organizations and systems.

The issue arises as to what should constitute the linkage between the representative and the public, that is, what relationship must be developed through which the public can voice their wants and gain access to the political process. Central in the selection of representatives, the role of the citizen is to make choices regarding alternatives presented to them by competing political organizations and leaders. From the expected behavior of representatives comes the idea of accountability. This is enforced by the citizenry, ultimately, by the voting process.

However, elections occur for the major leaders in the representative government of the United States once every two or four years. This seems to weaken accountability. This gap is decreased by the formulation of a politically oriented group responsible to both the representatives and to special interest groups. These "pressure groups" close the distance between governmental leaders and the governed by performing the dual function of making demands on behalf of its citizen groups and reporting back to its members.

This concept of dual representation provides a construct to explicate the creation and functions of consumer advisory boards. Here the dual representation consists of the relationships between the advisory board and the citizens of the catchment area and the relationship between the advisory board and the bureaucracy which is responsible for channeling the resources of the organization.

Participation in the Context of

Bureaucratic Theory

Many tenets of traditional bureaucratic theory run contrary to citizen participation. The vertical organizational structure tends to foster programming from the top levels of the organization, resulting in directives to line staff. Conformity and routine are emphasized. Since most of the line staff are treated according to rules, impersonality in human relations follows.

An organization's formal information network is usually based upon the hierarchy of the organization. What constitutes "issues" and "priorities" are usually determined within the organization and by the higher echelons of the organization. Involvement of citizen groups such as a consumer advisory board in these issues and priorities can be dysfunctional for administrative efficiency, as involvement with the citizens increases problems of communication, is time consuming, and complicates the

authority structure of the organization. Issues presented by the administration to an advisory board may be defined in terms of managerial and bureaucratic needs of the organization rather than in terms of the board's needs. Conversely, the advisory board's needs presented to the bureaucracy, can be translated into managerial and bureaucratic needs of the organization.

Also, basic bureaucratic tenets assume that the bureaucracy possesses the knowledge and organizational expertise to perform their prescribed functions. As much as possible, bureaucracies handle situations most effectively by grouping them into categories in which uniform rules are applied.

These statements concerning the nature of bureaucracies tend to run contrary to concepts of citizen participation. Yet, any organization in fulfilling its prescribed mandate makes decisions which contain value components. To the extent that an advisory board can develop strategies to affect that layer of the bureaucracy, then meaningful consumer input can occur and the inherent bureaucratic structure of the organization will be fulfilling the mandate of the advisory board. The natural social distance between the bureaucracy and the citizen can, within this context, be diminished.

As examples of such strategies, an advisory board possesses assets to affect the bureaucracy. They are not restricted to "rights" or negative sanctions of the

organizational structure of the bureaucracy. They are legitimate representatives of the community having access to the bureaucracy but without being employees of it. The bureaucracy must respond to the inputs of the advisory board. These are potential sources of power for a citizen advisory board.

The extent of success for citizen input into the bureaucracy will be highly dependent on the extent to which the consumer advisory board members are representative of the community, and the extent to which the advisory board resists co-optation by the organization.

Participation in the Context of

Organizational Theory

An organization can usually maintain its autonomy best by the consumers of its product playing a passive role. Traditional organizational theory as expounded by Max Weber viewed the consumer from this perspective. However, the riots of the sixties showed that consumers can organize, deny sanctions to an organization, and can resist the activities of the organization.

Modern organizational theory refers to a concept called "organizational sensitivity", that is, the conscious internal process of keeping an organization open to the life style and "needs" of its potential consumers. An organization will remain viable as long as it contains an internal system of self-regulation so as to constantly focus and refocus on its tasks.¹⁹ This requires multilevel,

consumer oriented inputs into the organization. This can be achieved by obtaining consumer feedback on its services, by hiring indigenous workers to participate in delivering the product of the organization, and by having meaningful consumer advisory boards. These measures can serve to lessen the distance between the organization and the public it serves.

Organizations, by necessity, must engage in exchange with other organizations and groups. As Peter Blau noted, however, these exchanges are always hindered by the threat (real or perceived) of losing autonomy and exclusive decision making power.²⁰ Consumer advisory boards' need to be aware of this. On the other hand, access will more likely be granted if the consumers' exchange is viewed as beneficial or even necessary to the organization. Most likely, the organization will attempt to manipulate the board members in this direction.

However, this in turn offers an opportunity to the board to engage in an exchange process with the organization, an opportunity which may be overlooked by the board members not trained in exchange theory.

The optimal social distance between the organization and its consumers in this study is viewed not in terms of either group maintaining control over the other but in terms of mutual cooperation occurring between the two groups. This is to be achieved by a consumer board acting as advisors to the organization as to the needs of the citizens

of its catchment area. These consumer advisors, optimally, are selected by and accountable to the consumers of the organization's catchment area.

Objectives of the Current Study

This chapter has explored the potentials and limitations of some key variables involved in consumer advisory boards' inputs into a community mental health organization. Based on these considerations the following objectives of this study have been formulated to increase the effectiveness of consumer advisory boards and to decrease the social distance between the community mental health center and its consumer advisory board:

1. To increase the board's understanding of their role, functions, and responsibilities
2. To improve communication between the board and the administration of the C.M.H.C.
3. To increase provider responsiveness to the concerns of the board

These objectives will be measured in this study. Besides these objectives to be measured, the following objectives of this study which will be incorporated into the training sessions are:

1. To increase the board's confidence in the legitimacy of their role
2. To increase their knowledge of the mental health system budgetary processes, organizational processes, and strategies

to negotiate proposals through the organization

3. To improve planning skills
4. To feel less alienated from the system
5. To achieve increased accountability from the organization
6. To promote a positive partnership between the board and the providers of the service
7. To develop skills at influencing policy
8. To improve group skills in group functioning, priority setting, and problem solving
9. To improve communication within the group and their ability to work together

The above objectives represent an ideal to achieve in training a consumer advisory board. Limitations on the ability to achieve this are affected by the characteristics of the specific board selected which will be explored in the next chapter.

FOOTNOTES

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CHAPTER III

CHARACTERISTICS OF THE PROGRAM SETTING

Since this study took place in a community mental health center, (C.M.JH.C.), this chapter will relate to some of the structural characteristics of this particular setting and the author's initial contact with its community advisory board. As background, the history of the community mental health center movement will be discussed.

The Community Mental Health Center Movement

The modern impetus toward interest in social psychiatry and the community mental health center concept received a dramatic input in the United States in 1908. It was in that year that Clifford Beer's, A Mind That Found Itself, was published. The purpose of this book was two fold. The author wanted to educate the public concerning the nature and causes of mental illness. He also wanted to bring to public awareness the deplorable condition of the psychiatric institutions of that time.¹ The goals of public education concerning mental problems and his efforts to "deinstitutionalize" the patient with emotional problems gave impetus to the social psychiatry movement and more broadly the community mental health movement but led to the

implementation of community mental health centers.

Prior to this time, our Nation's government had operated under the firm principle that most mental health problems, the maldistribution of resources, and the quality of these services were none of its affair. Mental health services were viewed as the responsibility of the States, local communities, and private charities.

However, within a year after the publication of Beer's book, a national focus upon the concerns of the mentally ill occurred. In 1909 the National Committee for Mental Hygiene was formed.² This national organization led a "grass roots" movement in the area of mental health care. It provided a focal point for citizen concerns and for action by workers in State and local affiliates of the organization. Its early interests were in improving the conditions of the mentally ill in local psychiatric facilities. The organization continued until 1950 when it merged with other interest groups to form the National Association for Mental Health.³

During this same period of time, changes were occurring in the psychoanalytic field which would have a major impact on the development of the social psychiatry movement. Previous to the development of Freudian psychoanalytic treatment of the mentally ill, state institutions provided what ideally was termed "moral treatment" for the mentally ill. The state institution had arisen as a reaction against local or private care of the

mentally ill which frequently consisted of custodial care in almshouses or even local jails. Initially, the state hospitals viewed the mentally ill person as one whose condition resulted from his life experiences. The state hospitals were established to provide a kind, "family" atmosphere for their patients, a simplified form of "milieu therapy." Dr. Thomas S. Kinkbride (1809-1883) established the rule that no more than 250 patients should be treated in any one state hospital - a rule adopted in 1851 by the Association of Medical Superintendents.⁴ This goal was abandoned due to the explosive population growth of the United States following the Civil War and the number of immigrants migrating to the United States from 1890 to 1910. In time, the state psychiatric hospitals became themselves vast warehouses for removing the mentally ill from the community, which was the very conditions that brought about their origin.

With Freud, the development of psychiatry began as a specialty of medicine. The focus of treatment shifted from "moral treatment to an organic focus with treatment based upon psychoanalytic considerations." The "medical model" of treatment arose wherein the ill person came to the doctor's office and receives treatment. This model was heavily influenced by early Freudian conceptualizations concerning the intra psychic nature of mental disorders.

In his latter positions, Freud emphasized more the importance of the ego which would lead to the development of

ego psychology. The neofreudians (Sullivan, Adler, Horney, Fromm) all deviated from the traditional psychoanalytic line because of their realization of the importances of extrapsychic factors in personality development and pathology. The impact of one's interpersonal relationships and the effects of environment on personality development would result in a merger of cultural, social, and psychological models which became known as social psychiatry. The "team approach" to the treatment of mental illness arose as well as the development of preventive paradigms. These concepts from the field of social psychiatry would ultimately find their expression in the development of the community mental health center.

Other events outside of the field of mental health also were occurring - events which would profoundly influence the field of mental health and, in particular, social psychiatry. The Great Depression of the thirties paved the road for Roosevelt's development of federal programs which replaced previous local and state programs. In particular, by the Social Security Act, the federal government assured permanent financial support for planning in mental health activities. Initially, the Act provided a small program of federal formula grants for the support of health services with a cap of \$17 million a year.⁵ As the program expanded, the role of the federal government in providing funds for the mental health needs of all of its citizens increased.

Another major event to affect the social psychiatry movement in America was the effects of U.S. entry into World War II. The war highlighted the severe shortage of trained psychiatric personnel to diagnose and treat mental conditions in the military. At the time of the war there were less than 3,000 qualified psychiatrists in the United States.⁶ The general public also learned after the war was over that 1,100,000 men had been rejected for military duty because of mental or neurological conditions.⁷

These awarenesses led to the passage of the National Mental Health Act in 1946 which provided federal funds for research into the causes, diagnosis, and treatment of psychiatric disorders, the training of professional personnel and assistance to the states for the establishment of psychiatric clinics and treatment centers. From this major federal legislation, there emerged during the next twenty years the wide-ranging programs of the National Institute of Mental Health.

Another major factor which gave impetus to the community mental center act resulted from advances in the field of psychopharmacology. With the use of psychoactive drugs, previous "backward" patients were able to function in less restrictive settings. The use of partial hospitalization programs and after-care programs were given new impetus (by this chemical attack upon mental illness).

Due to growing pressure for a general reassessment of the mental health program, the United States enacted the

Mental Health Study Act (Public Law 84-182) to provide for "an objective thorough and nationwide analysis and re-evaluation of the human and economic problems of mental illness" (Joint Commission on Mental Illness and Health, 1961, page 301). This involved a five year study. The final report was delivered in 1961 to the U.S. Congress. It was entitled "Actions for Mental Health".

The report strongly endorsed the new "community care" concepts from the field of Social Psychiatry, concepts whose application, for the most part, lacked empirical verification.⁸ However, when the report reached the desk of the new President, John F. Kennedy, it was strongly supported by him.

In February, 1963 the President sent to Congress a special message on mental health and mental retardation. This was the first time a President of the United States had done this. In his message he called for a "bold, new approach" on the part of the federal government in providing for the mental health needs of its citizens. Included was the need for a national mental health program, grants to the States for the development of comprehensive community mental health centers, provision for skilled manpower in this field and focus upon community rather than institutional care, providing comprehensive care, prevention programs and high-quality care.⁹

Congressional hearings began shortly after the President's message was sent to Congress. It culminated in

the passage of the Community Mental Health Centers Act.

The Community Mental Health Centers Act

As a consequence of the planning grants awarded to each state and territory in the United States prior to the enactment of the community mental health center legislation, mental health needs and resources had been inventoried. Each state had been divided into catchment areas, each with a population limit of 75,000 to 200,000. The catchment areas of each state were ranked by need for improved mental health services. The community mental health center construction and staffing legislation appropriated funds that could be combined with non federal funds for the construction and staffing of the mental health centers to be built in each catchment area. The federal share of construction costs ranged from one-third to two-thirds of the total cost (depending on the affluence of each state). As for staffing costs, the federal share was to start at 75% and decrease by 15% to each year until it reached 30%, after which time non federal funds entirely were to be used. Some 1500 catchment areas were created in the United States, and the hope was that in the coming decade each such area would be served by one of these centers.

As for the centers themselves, the act required that they provide five essential services : inpatient care,

outpatient care, emergency services, partial hospitalization, and consultation and education. Ultimately, five additional services were also to be provided: diagnostic services, rehabilitation services, precare and aftercare services, training, and research and evaluation. The services to be provided in each mental health center were to be available to all persons residing in the catchment area, including persons unable to pay for such services, and were to be readily accessible to the community being served. Further, the centers were to meet a number of regulatory requirements that would help ensure continuity of care. Included among these requirements were:

1. that a person eligible for treatment in one element of a community mental health center be eligible in all elements,
2. that patients be readily transferable from one element to another,
3. that clinical information about patients be shared by all elements of the mental health center,
4. that staff be able to move among treatment elements in order to follow their patients, and
5. that no minimum period of residence in the catchment area be imposed as a requirement for treatment.¹⁰

Several amendments to this legislation were passed over the years by Congress. The most sweeping changes

occurred in 1975 with the passage of P.L. 94-63, Title III.

This Act defines a community mental health center as a public or private non profit legal entity through which comprehensive mental health services are provided. Among the specific requirements placed by law on these centers are:

1. services within a defined geographic catchment area
2. services to any individual living in or employed in the catchment area
3. services to these individuals regardless of ability to pay, current or past health condition, or any other factor
4. services to ensure that clients have access to all other health and social services they may require
5. coordination with other health and social agencies, and with State mental health institutions
6. services which are available and accessible
7. services which are provided in a manner which preserves human dignity and quality of care
8. services which overcome geographic, cultural, linguistic and economic barriers
9. availability of services 24 hours each day, seven days each week
10. a governing body, representative of the catch-

ment area population

11. an on-going quality assurance program
12. an integrated medical records system
13. a professional advisory board composed of center staff members
14. an identifiable administrative unit responsible for providing consultation and education services

Section 201 (b) 1 of the Act defines twelve "services" which a CMHC must provide - an increase of seven over the five "services" required in previous legislation. Services are to be provided at the center itself and/or through satellite facilities, or through arrangements with health professionals and other professional providers in each catchment area. The National Institute of Mental Health has described the services as follows:

1. Inpatient services of a community mental health center must provide full-time hospitalization. A full range of activities are to be offered, e.g., milieu therapy, psychotherapy, chemotherapy, recreational therapy, occupational therapy, and medical treatment when needed.
2. Outpatient services of a community mental health center must be available 24 hours a day, 7 days a week so clients can function as they go about their daily lives. These services include diagnosis, evaluation, and treatment of psychiatric problems and referral to other entities and agencies, as needed.
3. Partial hospitalization services of a community mental health center are treatment alternatives to full-time hospitalization. Whether in day, night, evening, or weekend services, the client is treated in a therapeutic environment while maintaining family and community ties.

4. Emergency services of a community mental health center must be available 24 hours a day, 7 days a week. Programs consist of 24-hour walk-in service, 24-hour telephone service, home visits, and services to other agencies. A mental health professional must be available at all times.
5. Consultation and education services of a community mental health center shall be available to a wide range of individuals and entities including: health professionals, schools, courts, State and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies, and other appropriate entities. They must include a wide range of activities designed to develop effective mental health programs in the center's catchment area, promote the coordination of the provision of mental health services among the various entities, increase the awareness of the residents of the center's catchment area, promote the coordination of the provision of mental health services among the various entities, increase the awareness of the residents of the center's catchment area of the nature of mental health problems and available services, promote the prevention and control of rape, and provide proper treatment of the victims of rape.
7. Services for elderly of a community mental health center must be specialized programs including a full range of diagnostic, treatment, liaison, and follow-up services.
8. Screening services for a community mental health center must be available to courts and other public agencies which are considering individuals for referral to a State facility for inpatient treatment. Screening services are designed to assess, plan for, and link individuals with appropriate services to be provided in the least restrictive setting possible. Where appropriate, treatment must be provided for such persons through the center as an alternative to inpatient treatment in a State mental health facility.
9. Follow-up care for a community mental health center must be provided for residents of the catchment area who have been discharged from a mental health facility.

10. Transitional services of a community mental health center must be available to mentally ill residents of the catchment area who have been discharged from a mental health facility and to those who would without such services require inpatient care. Transitional services must include appropriate living arrangements and the mental health and other supportive of rehabilitative services needed to help clients achieve or maintain community adjustment.
11. Alcoholism and alcohol abuse services must be made available through the community mental health center for the prevention, treatment, and rehabilitation of alcohol abusers and alcoholics.
12. Drug addiction and drug abuse services of a community mental health center are a program for the prevention, treatment, and rehabilitation of drug addicts, drug abusers, and persons with drug dependency problems.

The Act does not specify the type of treatment to be provided (theoretical orientation/treatment mode) in each "service." In fact, several of the "services" described are really facility types or age groups rather than services as such. Several provisions - those calling for citizen participation, research, and evaluation - are designed to support the delivery of services.

In addition, P.L. 94-63 spells out the basis for several CMHC grant programs to support the legislated services. Among them are:

1. Section 202 - Planning - A one-year grant to assist a community in assessing needs and to design services based on those needs
2. Section 203 - Initial Operations - A maximum of eight one-year grants to assist a CMHC

in meeting the cost of its operations

3. Section 204 - Consultation and Education -
Not time limited, these grants are to assist the CMHC in providing its indirect consultation and education services
4. Section 205 - Conversion - A maximum of two awards can be made to assist CMHC's funded prior to P.L. 94-63 to expand their services to the twelve required by the Act
5. Part B - Financial Distress - A maximum of three one-year awards, to assist Centers in financial distress which would otherwise be forced to reduce services
6. Part C - Facility Assistance - A State prioritized grant to assist CMHC's with purchase, remodeling, leasing, construction, expansion, and initially equipping the Center
7. Part D - Rape Prevention/Control - to assist in investigation and study of the prevention and control of rape.¹¹

Contained within these regulations are the goals and objectives of a comprehensive community mental health center. The chief goals and objectives flowing from these regulations are:

1. As the term suggests, community mental health refers to all activities undertaken in the community in the name of mental health. Thus, the first characteristic that

distinguishes community mental health from more traditional mental health related activities is its emphasis on practice in the community as opposed to practice in institutional settings .

2. A second characteristic of this orientation is its emphasis on a total community or population rather than on individual patients. The term catchment area has commonly been used to describe the population that is of concern to a particular community mental health program

3. A third dimension is its emphasis on preventive services as distinguished from therapeutic services. These second and third distinguishing features of the community mental health orientation together represent the application of public health concepts to the field of psychopathology

4. A fourth characteristic of the community mental health approach is its emphasis on continuity and comprehensiveness of services. A community mental health program should be a system of services with easy flow of services and patients among its components parts. In addition, a program should meet the full spectrum of mental health related needs in the community.

5. A fifth characteristic of community mental health practice is its emphasis on indirect rather than direct services. One indirect service is consultation, in which a mental health professional attempts

to make a significant intervention in the lives of a group of people by working with persons who have access to specific social systems, such as teachers, religious leaders, or public health nurses, rather than directly with that system's members. Another indirect service is mental health education, in which mental health professionals, often using the mass media, attempt to reach large, undefined numbers of people in order to have a positive effect on their psychological adjustment

6. A sixth characteristic is the movement's emphasis on innovative clinical strategies designed to meet the mental health needs of larger numbers of people more promptly than has previously been possible. Of all the approaches that have been tried, the most popular have been brief psychotherapy and crisis intervention

7. A seventh characteristic of the community mental health orientation is its emphasis on a process of thoughtful and realistic planning regarding mental health programs. Such planning often includes the performance of demographic analyses of the community being served, the specification of unmet mental health needs, the identification of populations within the community that run a particularly high risk of developing the kinds of disorders generally identified as mental illness, the coordination of mental health services in a community, and the establishment of priorities within a community for

dealing with problems directly or indirectly related to emotional disturbances

8. An eighth characteristic of the community mental health orientation is its tapping of new sources of workers. Rather than viewing the traditional professions of psychiatry, social work, psychiatric nursing, and clinical psychology as the only suppliers of mental health personnel, the community mental health professional seeks to create new types of workers, and such terms as paraprofessional and indigenous mental-health worker have been coined to describe these new colleagues of the professionals in the community mental health center

9. A ninth characteristic of the community mental health movement is its commitment to what is usually called community control or community involvement. These terms mean that the mental health professional is not considered the sole source of information about the mental health related needs of the community or the best ways to meet these needs. Rather, the staff of a community mental health center is expected to join with the community or its representatives to identify needs, propose and evaluate programs to meet these needs, and plan for future program developments. The concept of community control suggest that a community mental health center operates on behalf of the community

10. A final characteristic of the community mental health center orientation is its interest in

identifying sources of stress within the community; its proponents don't assume that psychopathology always arises from within the individual patient

Characteristics of the Program Setting

This study took place in a large metropolitan city located in the northeastern section of the country. It occurred at a community mental health center which serves a small portion of the city's total population.¹²

This Center officially opened in July of 1978. According to a pamphlet published by the facility, this culminated a 12 year process of working with federal, state, city officials and local consumer groups.

This section will explore some of the characteristics of this Center and how these characteristics related to the design of this study.

One of the characteristics of this setting relates to the services offered by this particular community mental health center. Certain services for a community mental health center are mandated by P.L. 94-63 which is then monitored by the National Institute of Mental Health. All of the following services must be offered to the residents of the catchment area either directly by the community mental health center or by some other agency or agencies which are physically located within the catchment area (except by a special waiver from the National Institute of Mental Health). This latter arrangement is known as a

consortium agreement wherein the C.M.H.C. must establish a liaison with the other agency or agencies for referral and consultation purposes. This requires the advance approval of the National Institute of Mental Health.

There exists 12 mandated services for the establishment of a community mental health center. These services and how this center provides these services are as follows:

1. Inpatient services - a community mental health center must provide full time hospitalization with a full range of activities such as milieu therapy, psychotherapy, chemotherapy, recreational and occupational therapy, and medical treatment where indicated

Initially, this center obtained a waiver on this requirement. The psychiatric inpatient beds were provided by the Department of Psychiatry of the host hospital. This is located on the same grounds as the community mental health center. In 1982, the C.M.H.C. opened its own inpatient unit consisting of 21 beds and the array of services necessary. The unit also is a receiving hospital for the residents of the community. It provides acute psychiatric inpatient treatment and if further care is indicated, the patient is transferred to the State hospital which serves this area.

2. Outpatient services - these services must include

diagnosis, evaluation, and treatment of psychiatric problems and a referral mechanism

The Center provides this service employing mainly individual and group therapy to adults residing in the catchment area. To make the services more accessible, the clinic initiated evening hours. In addition, the clinic operates workshops on a variety of mental health topics for the residents of the area. The Center also operates a store-front facility located in a populous area of the Center's catchment area near a city housing project. Individual and group therapy is offered at this facility and referrals are made to the main facility when other mental health services are required.

3. Partial hospitalization services - this is a treatment alternative to full-time hospitalization. The services can be offered days, nights, or on weekends. In this setting the client is treated in a therapeutic environment while maintaining family and communities

This center provides a day-time partial hospitalization program which focuses on group therapy and group activities. The program provides traditional group therapy, recreational and art therapy and vocational therapy.

4. 24 hour emergency services - a community mental health center must provide crisis intervention

services 24 hours a day, 7 days a week. This component includes 24 hour walk-in services and 24 hour telephone services. A mental health professional must be available at all times

This center provides this service in accordance to Federal mandate. The Center initiated a training program for those staff members who receive the incoming calls.

5. consultation and education services - these services are to be made available to professionals and officials in the community such as the courts, schools, public welfare agencies, and the clergy. Their purpose is to make the community aware of the mental health needs of its citizens and to offer consultation on mental health issues. In addition, this program unit should promote the prevention and control of rape and provide proper treatment of rape victims

This Center provides workshops and seminars mainly directed at the clergy and school officials to fulfill this mandate. The Center meets with youth groups and high school students and presents programs on rape prevention. The Center distributes pamphlets in the community informing the residents of the Center's mental health services.

6. Services for children - a full range of diagnostic, treatment, liaison, and follow-up services must be provided

in a specialized unit for children

The Center has a discreet children's outpatient department located on the grounds of the community mental health center providing the mandated services. The Center treats children to age 17. If they require further outpatient treatment, they are referred to the adult outpatient program. This clinic also operates a remedial reading program for children with learning disability, providing educational and therapeutic treatment.

7. Services for the elderly - a specialized program of services for this group must be provided

This Center provides clinical services in the elderly's homes and provides a van to bring them to the C.M.H.C. Group therapy and activity - socialization groups are held. This program component serves residents of the catchment area who are 65 years of age and over.

8. Screening services - these services are intended for the courts and other public agencies who are considering referral of patients to a state facility for inpatient treatment

This service is provided by a different facility which maintains a liaison staff to the courts. The Center has a written agreement with a State facility which provides inpatient care for those patients requiring chronic care or a period of observation for court proceedings.

9. Follow-up care - for patients who are discharged from the mental health facility.

This service is provided by the Center as part of its regular referral process. Contact and referral is made to other agencies which may provide needed services to the patient.

10. Transitional services - these are services to be provided for discharged patients from the inpatient facility and, without which, further inpatient care would be required. These services must include appropriate living arrangements and other supportive or rehabilitative services needed to help patients achieve or maintain community adjustment

This Center, like most centers, provides these services as part of the patient's workup prior to discharge from the inpatient unit. A team consisting of the patient's physician, clinical nurse, and social worker consults with the patient and his relatives or community facilities to provide the transitional workup based upon diagnostic considerations of the patient's needs.

11. Alcoholism and alcohol abuse services - services for the prevention, treatment, and rehabilitation of alcohol abusers and alcoholics

This Center maintains a discreet outpatient alcoholism clinic located on the grounds of the hospital and a 10 bed detoxification unit. It is part of the hospital's

Department of Psychiatry, which maintains close affiliation with the community mental health center. Future plans call for an inpatient detoxification unit as part of the C.M.H.C. complex.

- 12. Drug addiction and drug abuse services - a program for the prevention, treatment and rehabilitation of drug addicts must be provided in the Center's catchment area¹³

The Center does not provide this service directly but works with store-fronts, detoxification units, and half-way houses sponsored by other organizations located in the Center's catchment area. This is mainly a consultative role.

Demographic Characteristics

Another major characteristic of a community mental health center consists of its demographic composition. The catchment area of the Center consists of approximately 206,000 people based upon 1970 census tract figures. (Since this figure is 6,000 people above the Federal mandate for the population of a C.M.H.C.'s catchment area, a special waiver must have been obtained.) The catchment area's population consists of the following:

Blacks - 120,000 (58%)

White - 80,000 (39%)

Hispanic and other - 6,500 (3%)

The area comprises approximately 111,000 males and 94,800 females.

According to statistics released by the Center, more females use the services of the Center than males; approximately, by 12% of the male-female ratio of the catchment area. In the outpatient program, 46% of the clients are between the ages of 20 and 44. Over 50% of the Center's clients are self-pay (as opposed to Medicaid recipients).

These figures would suggest that most of the area's residents are at least working class citizens who maintain steady employment. According to the Center's evaluation unit, the area consists mainly of lower middle class residents and some pockets of middle-middle class residents. Since the largest number of people are Black (58%), this may enter into the politics of the area and the politics of the community mental health center.

In a personal interview held with a city official responsible for the monitoring of the program, additional information concerning the characteristics of the Center was obtained. This interview was held in the spring of 1982. The public official wished to remain anonymous.

According to this official, the thrust for the development of this community mental health center originated from the sponsoring hospital. It was viewed as a means to enhance the hospital's influence and as a means to allocate additional funds to the hospital complex. Community support was solicited and obtained. The hospital's catchment area was used as the proposed catchment

area of the C.M.H.C. An advisory board to the proposed C.M.H.C. was initiated. Many of the original members of this board are still members of the advisory board. Initially, the thrust for the development of the board came from the hospital. The involvement of a community board in the development of the C.M.H.C. was viewed as a means to enhance the acceptance of their application with Federal, State, and City officials.

In addition, another hospital located within the same city is an affiliate of this hospital. Normally, the affiliate institution is influenced by the affiliator. However, in this instance, the reverse is true. The affiliated institution is a large medical teaching complex whose influence is felt around the city and into the chambers of the mayor's office. An administrator of the affiliate is the wife of the most powerful political figure in that section of the city.

As a result, the affiliate influences the policy and direction of the affiliator. The Director of the hospital was interviewed and approved by the Director of the affiliate institution. He is a Black person chosen, in part, since the majority of its area's population is Black. In the opinion of this public official, this Director is inept as an administrator and is subservient to the demands of the affiliate institution.

This information would prove valuable in the training sessions, especially in explaining the subsystem of

the organizational network.

Initial Contact with the Board

In a meeting with one of the author's advisors after submission of the project proposal, the names of two institutions which would fall within the scope of the project were given to me. In my contacts with both directors of these programs, a similar process occurred. Both directors indicated interest in the proposal and wanted me to submit copies of the proposal to them. They both stressed the necessity of their advisory board's acceptance of the training as a necessary condition for the study to take place.

This was viewed as a positive. In the past, training programs have taken place by gaining the approval of the director of the program or unit without any or little discussion by those workers who have to implement the study. Resistance could arise and the workers could co-op the study which may invalidate the results of the research.

At this point in time, the author had no idea as to which board would constitute the group that would receive the training and the control group that wouldn't receive training. The proposal was submitted to both directors. Characteristics of their advisory boards were unknown at this point in time. If one of the two boards accepted their involvement in the study, then the characteristics (age, sex, education, class affiliation, occupation, and membership on other local community groups) of this board would have to

be studied and attempts made to secure the approval of a similar board to act as the control group. Another anxiety at this point in time concerned the possibility that both directors and their local mental health advisory boards would accept the proposal.

Fortunately, this did not occur. The author met with the director of one of the community mental health centers. Discussion was held regarding the proposal and a copy was presented to him. He appeared genuinely interested and asked several relevant questions concerning the proposed training sessions. The fact that the training sessions did not involve solely a fixed agenda appeared to impress him. The author stressed that the contents of the sessions would be primarily arrived at between the board, the administration, and myself. I also stressed my realization of remaining sensitive to the administrative needs of the C.M.H.C. This veiled reference to the politics of the C.M.H.C. was viewed as necessary so that intervention strategies would not be construed as "rebel-rousing" or creating antagonism between the board and the administration of the C.M.H.C. The author informed him that he or his designated subordinate would be kept appraised of the contents of the training sessions both in terms of the on-going process and the planned following sessions. Again, he appeared to take these remarks in a positive manner but did not reveal any areas of sensitivity concerning his board or the administration's relationship to the board.

He stated that he would be meeting with the chairperson of his board and would recommend acceptance. He or the chairperson would contact me the following week to indicate whether or not they were interested in participating in the project.

The following week no one called. The author waited another week and then contacted the director of the C.M.H.C. Giving no direct explanation as to the reasons for the lack of contact, he indicated that the chairperson felt the board's agenda was too full already and, hence, they did not have time available for this proposal. From the tone of the conversation, the author of this study concluded that further efforts would be futile. The actual process of what occurred can only be a matter of speculation.

Within this same time span, the author contacted the director of the second C.M.H.C. A meeting was arranged at his office. In the initial discussion with him, he commented that the board would probably be very glad to receive this training, which was at marked contrast to the meeting with the other C.M.H.C. director. My presentation of the proposal was similar to my meeting with the other director. I presented him with a copy of the proposal. He informed me that he would present my proposal to the chairperson of the advisory board and they would discuss the project.

It is to be noted that in both instances of my meetings with the two directors, I was not given direct

access to the board chairpersons or the members of the board which may reflect a close association between the administration of the C.M.H.C. and the board chairpersons.

The director informed me concerning some of the characteristics of the board. It is approximately 50% White and 50% Black, roughly estimating the population of the catchment area. The director's secretary takes the minutes of the meeting and would be available to me during my presentation. I requested to review the minutes of past meetings if the board accepted my training proposal and the director was agreeable to this. He also gave me the name of the chairperson of the board and noted that there is an annual election of officers with a maximum of two consecutive terms for any one person. The current chairperson is in her second term. It was agreed that he would phone me after meeting with the chairperson.

Two weeks later the author received a telephone call from the director. He informed me that the chairperson had decided to take my proposal to the board's executive committee for discussion prior to submission to the board members.

The executive committee consists of the chairperson and four other members of the advisory board. They meet two weeks prior to the monthly board meeting with the director of the C.M.H.C. to discuss the agenda of the meeting and any other relevant concerns.

The director informed me that I was to attend this

meeting. The director commented that this procedure was typical of the board. Any decision is resolved by taking it to committee. He also informed me that the issue had arisen as to my qualifications to give the board this training. He stated that he thought this issue had been resolved but did not elaborate. The meaning of this became clearer after I had met with the advisory board (which will be explained in the discussion of my initial meeting with the board).

The next step was the actual meeting with the executive committee. All members were present. All were women. The director of the C.M.H.C. also was present. The plan of the meeting called for copies of my proposal to be sent to each of the members ten days before the meeting. They noted that they had received my proposal in the mail yesterday and had not had time to review it. It was necessary, therefore, to refer them to the pages relating to the proposed summary of the project. They were also referred to the pages relating to the topic areas of the training sessions.

Since the board members had not reviewed the proposal, I informed them briefly of the history of the project, its goals, and the nature of their involvement, focusing upon the board's involvement in the topics to be discussed. In this discussion, I asked them regarding topics of possible interest. The chairperson spoke of the problem of attendance to the subcommittee meetings and her concern over what techniques the board could use to obtain funds

for the C.M.H.C. I noted that the latter is one of the areas included in the discussion of budgets and budgetary processes. The issue of attendance would be part of the discussion regarding organization and decision making processes.

Following this discussion, the group voted unanimously to allow me to present the proposal to the advisory board at their meeting. The author requested permission to review the minutes of previous meetings to obtain some idea of the board's activities and interests. They agreed to this. I also discussed the pre questionnaire, requesting permission to administer it at the board meeting. The group consented to these requests.

Review of Previous Board Minutes

Prior to my first meeting with the board, the author reviewed their past minutes over a period of eight months. Although a content analysis of these minutes will be presented in a following chapter, a few general, descriptive statements will be made to round out this chapter on the characteristics of the setting.

The board meets once a month. The official roster of the board members consist of 25 although four of these people are known staff members of the C.M.H.C. Average attendance during this period was 15.

The major concerns addressed by the board emanated from the administration of the Center. The major concerns

related to funds for the Center either in terms of proposed cuts in programs or in terms of obtaining additional funds for programs. The board was requested to send letters to various political figures or to attend meetings on these topics at federal, state, or local funding organizations. In these public meetings, they represented the "community" of the community mental health center. For the most part, the board responded positively to these requests. From the minutes, it appeared that little exchange process occurred between the board and the administration. The administration requested their assistance and they complied. In those instances where the board made requests to improve the services of the Center, feedback on their requests by the director of the C.M.H.C. occurred but the responses were frequently misleading or, in one instance, a canard.

There existed some concern about recruitment of new board members and information was exchanged regarding public meetings on issues relating to mental health. In one instance, the board expressed concern about a hospital practice which influenced the delivery of patient services.

In general, the board responded to the requests of the administration, playing a passive role in the mental health delivery system.

The Limitations of the Board's Representativeness
and Current Functioning

The board consists of 25 members with an average

attendance of 15 members. The extent to which such a body can be representative of a community consisting of 206,000 people, which is approximately half Black and half White, appears questionable. The extent of their representativeness will be further explored in a following chapter based upon the pre questionnaire.

As seen in the section on services of the center and its close linkage to the medical hospital, the center is part of a large, complex organizational system. The center's formal information network is part of the hierarchy of the organization. As reflected in the minutes of the advisory board meetings, what constitutes "issues" and priorities are established elsewhere within the system. Involving the consumer board in these issues and priorities can be dysfunctional for administrative efficiency, as involvement increases problems of communication, is time consuming and complicates the authority structure of the organization. The "issues" presented to the board are defined in terms of managerial and bureaucratic needs of the organization rather than in terms of the board's needs. Professional language is interpreted to them, often masking the values contained in the statements.

In addition, in such a large medical complex, the board's resources within the organization are fragmented. The concerns of the board were presented to the director of the C.M.H.C who then related to other people or groups within the organization and reported back to the advisory

board. Such a process would leave the board in a helpless position to negotiate directly with those involved or responsible for their areas of concern.

The advisory board also had little direct contact with the suprasystem of the organization. This involved the medical hospital and, more importantly, the affiliate institution. This would seriously curtail the effectiveness of the board and limit, in scope, the training sessions.

Other limitations will be explored in the following chapters.

FOOTNOTES

1. Clifford A. Beers, A Mind that Found Itself (Garden City, New York : Doubleday and Co., 1960, reprint ed., (Longmans, Green and Co., 1908), pp. 41-54.
2. Coordination : Health Planning and Community Mental Health, (U.S. Department of Health, Education, and Welfare : August 1979), p. 8.
3. Ibid., p. 8.
4. Richard H. William, Community Mental Health (San Francisco : Jossey - Bass, 1968), p. 21.
5. Coordination, p. 10.
6. William, Community Mental Health, p. 29.
7. Ibid., p. 29.
8. Bernard L. Bloom, Community Mental Health (Monterey, California : Brooks/Cole Publishing Co., 1975), p. 24.
9. Ibid., pp. 25-31.
10. Ibid., p. 31.
11. Coordination, pp. 51-55.
12. The City, the name of the Community Mental Health Center, and the names of the participants in this study will remain anonymous. This request was made by the advisory board members. Further explication of this issue is contained in the discussion of the author's interactions with the board members below, see Chapter IV, page 100.
13. Orientation Manual for Citizen Boards for Federally Funded Community Mental Health Centers, U.S. Department of Health and Human Services, Rockville, Maryland pp. 3-4.

CHAPTER IV

THE PROGRAM DESIGN

This chapter will examine the interaction of the author with the advisory board and the interaction within the board during the training sessions. The Program Design also will be presented.

Initial Contact with the Board.

As agreed with the Executive Committee, I attended the following session of the Community Mental Health Center's Advisory Board. This occurred in March of 1982.

Twelve people were present for the meeting. These included the Director of the C.M.H.C and his secretary and a psychiatrist who works at the institution but also resides in the catchment area of the facility. Her presence as a "consumer" or potential "consumer" of the service is questionable. However, all of the board members were cognizant of her position in the C.M.H.C. Three other members were community mental health workers who are employed by the Center. One of these three does not reside in the catchment area. In effect, then, six members were true "consumers" in that they were residents of the center's catchment area and were not employees of the Center. Whether

or not they had used the services of the center personally remained to be explored.

The tryst was held in one of the more spacious rooms of the C.M.H.C. The chairperson was not present and had been excused from the meeting. The session was conducted by the vice chairperson. The meeting was called to order and the previous month's minutes were read and accepted. A guest speaker, one of the administrators of the center, presented the proposed budget for the C.M.H.C.'s coming fiscal year. His presentation consisted of a categorical listing of proposed expenditures.

The presentation of the budget (contained in the minutes of the meeting) was as follows:

Personnel Expenses	-	\$2.7 million - an increase of \$.4 million due to salary increases
Fringe Benefits	-	last year requested \$570,000, now requesting \$670,000
Travel Expense s	-	last year requested \$4,000, now requesting \$1,000
Equipment Expense s	-	last year requested \$11,000, now requesting \$24,000 due to major equipment needs for the inpatient unit
Supplies	-	last year requested \$35,000, now requesting \$20,000
Construction Expense-		none last year, now \$8,000 for alteration on the fourth floor,

School of Nursing (lighting,
buzzer system, etc.)

Other Expenses	- last year requested \$360,000, now requesting \$200,000
Total	- last year \$3,300,000, this year \$3.6 million
Indirect Charges	- last year \$700,000, this year \$800,000
Final Budget	- last year \$4 million, this year \$4.5 million

Although it is not contained in the official minutes of the meeting, group interaction occurred following this presentation which reflects the attitudes of some board members.

Following this presentation of the Center's \$4.5 million budget, one of the board members asked if it would be possible to obtain a coffee pot for the advisory board from this budget. The administrator responded that this request would have to be made through the controller's office of the medical hospital. He also indicated that this would present a problem in that it involved a category of expenditures not included in the budget and, hence, would require State/City approval. Discussion on this topic then ceased.

Several board members then requested that separate funds under "transportation expenses" be established for the sole purpose of paying transportation expenses for board

members to attend the meetings. The same arguments were used by the administrator as for the reason they could not obtain a coffee pot. Several of the board members spoke of the indignity of having to go to the hospital center and fill out forms to obtain reimbursement for transportation - an expenditure of \$1.50.

The Director of the C.M.H.C. informed the board of a pending Youth Leadership Conference sponsored by the C.M.H.C. The board members were requested to place posters in their local areas to advertise the event. They were also informed that a table at the conference will be set up for them to elicit new members.

Other business discussed was the completion of a patient satisfaction study in the partial hospitalization program. The results of the study and the methodology of the study were not presented. However, the psychiatrist who completed the study wanted to use it for studying attitudes of discharged patients. Several board members felt it would be a waste of time asking former patients what they thought of the service since the patients are "crazy" and, hence, their answers would be meaningless. As one of the members put it, "how can you get a well answer from a sick patient?" The issue was not resolved.

The official minutes of the meeting presented this discussion in a very different light. The minutes read, "A discussion ensued by the board members as to the necessity and true value of such a study."

This interaction produced a problem for the project design. Since a content analysis of the minutes will be used on a before-after basis to test the propositional statements of this study, the question arises as to the extent of accuracy contained in the official written minutes of the meeting. Only the written minutes of the meetings prior to the intervention strategy are available at this time. The author decided that interviews with board members would be used to obtain a broader picture of these meetings and the author would take his own minutes both during the training sessions and for several sessions following the completion of the training. This design will be incorporated into the project of this study.

Following this formal presentation of the meeting, the author was introduced by the Director of the C.M.H.C. The presentation of the proposal was similar to the presentation made at the executive committee meeting, stating the goals and use of the training project. Few questions were raised by the members of the board. The author introduced several potential topics but little response was elicited. One member indicated that she wanted to think about it and would report back at the next meeting. She was not present at the following meeting.

It was explained that the sessions would take approximately three quarters of an hour for five or six sessions. Since the budget had just been presented to the group, the author viewed this as an opportune time to have

the first session consist of the budget and budgetary processes, since this constituted the main area of discussion during the session. The group appeared interested in this topic area. The author informed the group that a more detailed knowledge of a budget and budgetary processes would enable them to better understand the Center's program. The group agreed to this topic area. The group was informed that the author would distribute a blank copy of a budget as part of the discussion next month. (This budget is contained in Appendix E.)

The group voted (in my presence) to accept the training project. The propose of the pre questionnaire was explained to them. Some filled it out during the session while others took it home to return at next month's meeting.

The group did request that the name of the institution and the participants remain anonymous in the written report. The author agreed to the request. In general, the discussion followed the outline of Session I of the content of the Training Sessions as contained in Appendix B.

This outline consisted of:

- A. Establish a climate - state purpose, objectives of the sessions, determine groups resources and resistances, determine their degree of motivation
- B. Establish mutual planning based on group's interests - assess needs of the group and meaningful points of intervention - establish role of the

trainer

- C. Establish a contract - goals of sessions and how to obtain them - discuss content of sessions and reach mutual agreement
- D. Discuss group problem solving processes - methods to achieve goals of a group and roadblocks which prevent achievement of goals

In this initial, face-to-face contact with the board members, the author gained the impression that they were somewhat fearful of me. In part, this could be explained as due to someone new coming into their group and the unknown nature of the changes which might result. This could be fearful for both the administration of the Center and for the board members. Since this board has been functioning for years, role relationships within the group have been established. The training could be viewed as a threat to these role relationships. This will become apparent in the description of the training sessions.

Characteristics of the Administrator and Individual Board Members

This section will describe some of the personal characteristics of key board members in order to present a fuller descriptive picture of this project.

The training project took place following each monthly meeting of the board. All members present stayed during the presentation except for the Director of the

facility and his secretary who took the minutes of the meeting.

The Director of the C.M.H.C. is a distinguished looking, middle age man. The Director was very sensitive to the feelings generated in the group process and was very effective in relating to the feelings of the group. Most requests or demands made on him by the group were dealt with by his need to discuss the issue with some other unit director of the facility. He seemed more comfortable dealing with issues behind the scenes. His formal role in the group appeared as one of a liaison.

The chairperson, who was in her second year of office, was a middle-age woman. She seemed to enjoy her role as cynosure of the group and, at times, would manipulate the group processes to ensure it. Upward mobility seemed important to her and her presence in the group may reflect some of these needs. As chairperson she frequently represented the advisory board at various Federal, State and local meetings and, as chairperson, wrote various letters to public officials concerning the demands of the community advisory board. At all times during the sessions, she was supportive of the director of the facility and frequently made laudatory remarks concerning him in the meetings. Her remarks were occasionally infelicitous and displayed a lack of understanding concerning appropriate ways to deal with problems presented by the group. Several group members voiced negative feelings towards her outside

of the meeting and not in her presence.

The vice chairperson was a middle-aged Black woman who attended the sessions on a sporadic basis. Her presence was assured when the chairperson was not present and, like the chairperson, seemed to enjoy the role of group leader. Her manner was pretentious and occasionally, without awareness, displayed a lack of knowledge regarding the issues, presenting them in a simplistic manner. Although supportive of the director, she was much less so than the chairperson.

The psychiatrist who resided in the catchment area attended the meetings religiously (she also attended all of the training sessions). She related to the group in a feisty manner. More importantly, she played the role of the "expert" in all matters in the meetings and in the training sessions. This issue will be discussed in more detail in the section on the training session. However, at this point it should be noted that the author was viewed from the beginning as a threat to her role position in the group.

Another prominent member of the group was a heavy-set Black woman who played a hostile role in the sessions which, at times, bordered on diatribe. (She was the person who asked if the group could obtain a coffee pot after the Center's presentation of its \$4.5 million dollar budget for the coming fiscal year.) She was one of the original members of the advisory board. When attention was paid to her in the meetings, she tended to become more

placid. This rarely occurred.

Another member of the group was an elderly woman who had been a board member since the inception of the board. She seemed genuinely interested in improving the services of the center but felt frustrated at times in doing so. During one of the sessions she mentioned that she had referred a prospective patient to the community mental health center for outpatient therapy. The person disliked the therapist assigned to him and requested to be assigned to a different therapist. After several requests, the person dropped out of treatment.

The rules and regulations regarding transfer of therapists were explained to her but the impression left was one in which she did not feel comfortable about the process.

Another member of the group was a young social work student who seemed to attend the sessions as a learning experience for her professional development. She was articulate and intelligent but seemed to lack any real concern for the problems of the Center or the group.

Three other members who attended were employees of the Center's storefront. Their interests seemed limited to any discussion of the quality of this program and to discussion of possible fiscal reductions in their storefront. Otherwise, they played passive roles.

The other members of the group played less pronounced roles and their attendance was sporadic.

The Program Design

The overall goal of this project was to improve the delivery of mental health services by developing meaningful consumer input into the mental health delivery system to a targeted population.

The following objectives of the program to be measured in achieving this goal are:

1. To increase the board's understanding of their role, functions, and responsibilities which will be reflected in an increase in the number and types of the board's activities
2. To improve communication between the board and the administration of the Center
3. To increase provider responsiveness to the concerns of the board

To operationalize these objectives the following major substantive propositional statements of this demonstration project have been formulated.

If the advisory board of a mental health center receives a training program which clarifies their role and activities and educates them in the mental health service delivery system, organizational processes, and group decision making processes, then higher levels of consumer participation will occur.

This propositional statement is based on the rationale that consumer advisory boards function more effectively when they receive formal training concerning their role within the organizational matrix and the mental health delivery system.

This proposition contains two key variables. The training program is the independent variable of this proposition. It is operationalized to mean the contents of the training sessions as contained in Appendix B.

The contents of this material was based upon a review of the literature as to those topic areas a community advisory board requires knowledge of to fulfill their roles. The chief areas consisted of:

1. analysis of the budget and budgetary processes of a C.M.H.C.
2. organizational analysis and decision making within an organization
3. methods of credentialing
4. program evaluation
5. patients' rights

In all of these topic areas, the focus in the training consisted of the role of the advisory board regarding each area rather than just a theoretical discussion of the topic areas. Efforts were made to elicit the interests and concerns of this particular advisory board in each topic area. A review of the available literature in

each topic area was made to determine the contents of the particular topic. The last two topics, program evaluation and patients' rights were requested directly by the board members.

The major dependent variable is "higher levels of consumer participation." It will be operationalized to mean a change in the number of activities performed by the advisory board and by changes in the types of the advisory board's activities. This will be measured by a content analysis of the board's minutes using a before-after study. It also will be measured by conducting personal interviews with the board member following completion of the training sessions. This will broaden the evaluative component of the study by obtaining a descriptive analysis of the board members perception of increased participation in the meetings.

The second major propositional statement of this demonstration project is:

If the advisory board of a mental health center receives such a training program, then substantive changes will occur in the relationship between the advisory board and the administration of the Center. The dependent variable "substantive change" will be operationalized to mean all non procedural changes in the relationship as measured by a content analysis of the advisory board minutes. Again, personal interviews with the board members will be used also to obtain a descriptive analysis of the change or lack of it.

To test these propositions the author initially planned to use a compromise experimental group-control group design. Since randomization was impossible in the study, equivalence of the two groups would be approximated by testing the similarity of the two groups in the pretest for such relevant factors as age, sex, education, occupation, and social class. The means of the two groups and the standard deviation would be used to determine the extent of similarity of the two groups. While this analysis will be performed, in actuality, the control group is a non equivalent one and, hence, a comparison group design was necessary. The experimental group and the control group are similar in that both are community advisory board's to a community mental health center located within the same city.

This compromise occurred because of the author's difficulty in receiving permission from a community mental health board to act as the control group. Due to the author's knowledge of the area, contact was made with the director of a C.M.H.C. whose board membership and ethnic composition of its catchment area was similar to the experimental group. He requested a copy of my proposal which was sent to him. In a couple of weeks he contacted the author indicating that he had discussed the issue with the members of his board who felt they did not have the time to engage in all the research projects which different students submit to them.

Since the control group's involvement consisted of

filling out the pre questionnaire (which takes about five minutes) and allowing the author to do a content analysis of their minutes, this response may be difficult to understand. Several other boards were contacted with the similar results. It is speculated that these boards non involvement may have been based on their failure to perceive any benefit in participation for themselves. Finally, a board was contacted through the intervention of one of the author's facility advisors.

The Training Sessions

Session I

The Budget and Budgetary Processes

Copies of a blank budget from the City funding source for the community mental health center were distributed to the group. This budget is basically a line-by-line budget with some elements of a lump sum budget. This budget is contained in Appendix E.

The initial discussion centered on the importance of the budget to all organizations. It was explained that the budget is the main source of power within any organization. The fact that most organizations do not allow its members to review their budget while attempting to elicit people's monies and resources was discussed with the group in terms of their current membership in these organizations. None of the group members had knowledge of or access to the budgets of any organization of which they are members such

as their places of employment, churches, or civic groups.

It was explained to the group that a budget basically is a plan of the expenditures (costs) for a given time period. The budget shows the anticipated profits (revenues) and losses (costs).

To explain the line-by-line budget the 240A page which summarizes all costs and revenues was used. The meanings of the various terms such as "personal costs", "other than personal costs", "accruals", third-party payments; "net", "adjusted net", and agency contribution were explained to the group.

One of the group members did not know the meaning of the initials, S.E.P., neither did the trainer. The psychiatrist who attends the consumer board meetings did know and the trainer acknowledged her contribution to the session.

The purposes of a line-by-line budget were discussed and how it achieves accountability, control of expenditures by the funding agency, and how it is subject to audit.

Discussion then centered upon how to use this analysis of a budget to determine the priorities of an organization. This involved viewing the budget by each program element and the projected revenues from each program element.

Following this, the discussion centered on the flexibility contained within the center's budget even given

the constraint of a, basically, line-by-line budget. The author mentioned that monies can be shifted from "personal expenses" to "other than personal expenses" within certain restraints. The group was very interested in the allowable percentage of shift and the restraints governing this reallocation of funds.

The concept of a budget was presented as a plan of expenditures which can be modified during the contract year. How these expenditures relate to the priorities of the organization were discussed. Other examples of the flexibility contained within the budget was presented to the group.

Most of the lay members of the group expressed dismay that the fringe benefits of the employees ranged between 23% to 27% of their salaries. (Apparently, this analysis of a budget was a new experience for them.)

This focus upon the inputs into an organization contained in a line-by-line budget was contrasted to the lump sum budget which focuses upon the outputs of an organization. The development of Program Planning and Budgeting Systems (P.P.B.S.) was discussed with the group. The 600 forms contained in the budget were reviewed with the group. How this analysis uses cost benefit analysis, benefit-cost ratios and cost effectiveness analysis on a comparative basis was discussed, producing considerable group interaction. The problems of a P.P.B.S. system such as its assumption of causal linkages, its assumption of a single

hierarchy of values within an organization, and its failure to realize that many issues are intractable within an organization was discussed.

The procedure for submitting contract modifications during the fiscal year was explained to the board including the board's need to be aware of these budget modifications in order to understand the agency's budget. This led to a discussion of the board's role in the preparation and approval of the agency's budget and budget modifications.

The group was especially interested in knowing where the funds allocated to the advisory board were contained in the budget. It was explained to them that these funds were contained in the category, "other expenses." The group seemed surprised that their allocation of funds was so non specific. This produced considerable interaction within the group as to the legitimacy of their requests for separate funds from the hospital. The focus had been shifted from State/City requirements to the doors of the hospital's administration.

Session II

The C.M.H.C.'s Organizational and Decision Making Processes

Prior to this session, the author had requested that a blackboard be provided for the presentation. Two maintenance men brought a blackboard into the room prior to the beginning of the session. The request had been made to the administration of the Center. One of the board

members commented to the trainer her pleasure that this request had been fulfilled.

The session began with a presentation of the traditional mechanistic model of organizations based upon Max Weber's analysis. Most of the board members seemed knowledgeable concerning this aspect of the presentation.

Some of the problems associated with this analysis of organizations such as its assumption that economic rewards motivate people in an organization and its lack of viewing the informal network within an organization led to a discussion of organistic models of organizational analysis.

A systems model of organizational analysis was placed on the blackboard indicating its input resources, components of the conversion process, storage and outputs. The main focus of this section related to the meaning and functions of the system's suprasystem. The importance of this aspect of a system theory analysis was discussed with the group from the viewpoint of the advisory board. The suprasystem was described as the road to influence for the advisory board. It was noted that in past meetings members had spoken of dealing with any issue by taking it to the Director of the C.M.H.C. It was suggested that in some situations that may be the wrong direction which led to a discussion of an organization's sensitivity to its suprasystem. It was pointed out to the group that the more the advisory board represents the community, the greater its influence on the system. This was presented in terms of a

shared working relationship between the board and the Center.

Concepts regarding exchange theory were discussed with the board members in terms of their relationship with the Center and how in the past the board had not used these opportunities to achieve things they wanted from the Center. The passive role of the board within the process was discussed. The need of the board members to become representative of the various power groups in their local community was reviewed.

This led to a discussion of the roles of a community advisory board to a community mental health center such as the preventative role, alternatives to hospitalization and the fact that a person does not necessarily improve by psychiatric hospitalization. The need for family involvement in treating mental illness and the fact that mental illness is usually not an all-encompassing illness was discussed within the contents of advisory board involvement in these processes.

The discussion elicited considerable interests from the board members. Several brought up examples of related activities which the members of the group could perform on an informal basis as members of the community such as the educating role and the enabling role.

Other possible roles of an advisory board were mentioned such as expressing priorities to the administration assessing the Center's delivery system,

identifying problems in the community, to report community reaction to the Center's programs, and recruiting volunteers for the Center.

Other theories relating to the board's influence upon the organization and methods of moving its proposals through the organizational structure were discussed such as decision making theory and cybernetics.

This part of the session elicited little commentary and may have been difficult for some of the board members to understand.

Session III:

Credentialing

This session dealt with the various types of credentialing and other forms of governmental monitoring of community mental health facilities. Emphasis was placed on the role of an advisory board in each of these processes such as presence at and participation in the exit interviews with these authorities.

The problem of the limited accessibility of the Center's van arose during the meeting. This van is also used by the Center's medical hospital to provide services to one of its units. Since this issue had arisen in the past, the role of the Center's Director in discussing the issue with other components of the hospital was discussed. An alternative approach wherein the directors of the other units would be invited to the advisory board meetings to discuss

the problems with them was proposed. The psychiatrist who resides in the catchment area and who attends the meetings seemed surprised at this idea. Although there was no immediate follow up (due to the summer recess of the group), the idea seemed to leave a strong impression upon the group members.

Another consumer member of the board raised the issue of referrals to the community mental health center. She had referred a patient for outpatient therapy who disliked his therapist and wanted to be assigned to another therapist. No action was taken and the patient dropped out of the program.

The author inquired as to the extent of this problem at the Center. No response was elicited. Upon questioning, the board member did not know all of the circumstances involved in this case. Methods of a patient to deal with this problem was discussed including the patient's right to discuss the issue with the therapist's supervisor.

Recently, a Federal site visit had been made to the Center. The board had little involvement in the process. They were given a copy of the Center's response to the Federal government's evaluation. It was noted that they should have seen a draft reply for the board's input into the Center's response.

The three main types of credentialing of a community mental health center were presented along with the

advisory board's involvement in them. It was explained that accreditation although not a governmental body, can exert considerable pressure on an institution such as the Joint Commission on Accreditation of Hospitals. This body conducts a site visit to an institution, evaluates its program, and lists institutions in a publication which it has approved. Its purpose is to establish standards and create goals for the institution to strive towards. It was recommended that board members be present at their exit interview with the facility to better understand the strengths and weaknesses of the facility and the role the advisory board can play in improving the system.

Certification was discussed with the group. Like accreditation, certification is performed by a non governmental body. It sets standards based upon formal education, work experience and possibly, a test. The person is validated by the body. The example of the A.C.S.W. certification in social work was used. The need of the advisory board to be knowledgeable regarding these certifications when reviewing candidates for positions in the mental health center was explained to the group.

The third type of credentialing, licensure was discussed. This is a police power which gives a person the right to engage in a certain practice. It sets minimum standards with possible disciplinary actions and possible withdrawal of licensure. Recent examples as reported in local newspapers were discussed. In some states an

operating certificate for a given time period is granted by the licensure agency. Again, the need for advisory board members to be aware of the various professional licensures was explained to the group.

The purpose and functions of the Programs Standards and Review Organizations (P.S.R.O.) was discussed. Since this is mandated for Medicaid and Medicare reimbursement for the medical center, the strengths and weaknesses of this peer review was discussed with the group. Its purpose as a cost control mechanism and the limitations of this was discussed. The role of the Health System Agency (H.S.A.) also was discussed.

Most of the group members seemed interested in this material although little immediate discussion occurred.

Session IV

Program Evaluation

This session centered on the topic of program evaluation in a community mental health center. Types of evaluation done by the Center or by the board itself were discussed. The fact that some advisory boards have an evaluation committee was presented to the group.

The issue of program evaluation as a channel for consumer response to the Center's program was presented to the group. The need to be aware of costs, time, and politics in performing evaluations of units was clarified to the group.

Most of the group took an active interest in this presentation. Again, the focus was upon the role of a consumer advisory board in program evaluation either directly or in reviewing and making recommendations on the Center's research findings. The advantage that consumer program evaluations can be on-going while most program evaluations of the Center are time-limited was pointed out to them.

The dual function of an advisory board of receiving evaluation studies from the Center and also suggesting areas of study for the Center was discussed with the group. A brief presentation was made on the use and limitations of social indicators, management information systems, and organization research.

The trainer brought to the meeting a N.I.H.H. publication, A Manual of Simple Program Evaluation, which was reviewed by the board members during this session.

Program Evaluation was explained to the group as meaning the collection and analysis of data to determine the effectiveness of the Center's program. The major areas of program evaluation and types of studies done in each area was discussed with the group. This discussion followed the outline contained in Appendix D.

The different sources of information available to the board were discussed with the group. These included the Center's annual evaluation, their levels of service per program unit which are reported monthly to the city and

state, the description of the Center's program contained in the contract's 600 forms, client satisfaction studies, and research studies performed by the C.M.H.C. It was pointed out to the group that an appropriate role for the advisory board would consist of the Center reporting to the board its research findings and the board recommending areas of program evaluation studies.

Since the topic of program evaluation is such a broad area the author offered to discuss any particular problem of the group and ways to conduct a study of the problem. The group seemed most interested in methods of conducting client satisfaction studies. The different approaches were discussed with them.

Session V:

Patient's Rights

This session focused on patient rights. The group had requested a session on this topic. The author brought to the session several books and pamphlets which discussed this issue.

During the session, the group voiced their lack of awareness as to whether the Center had a statement of patient rights posted on the inpatient unit or other areas of the Center. The need for this information to be made available to patients at the time of intake was presented to the group. The Chairperson felt that a bill of rights should be given to each patient upon admission. (The

administrative representatives present at the meeting made no comment on this issue.)

The history of litigation on the issue was presented along with the pros and cons of the "non-compliance versus the rights of patients debate."

A discussion also was held on what actions, legally, a citizen can take to hospitalize someone in the community, dealing with voluntary and involuntary admissions. Most of the members present played an active role in this discussion as it seemed to meet the needs and interests of the group.

A copy of the local state's Mental Hygiene Laws was distributed during the meeting. Those sections which related to psychiatric inpatient care were discussed during the meeting involving such issues as voluntary and involuntary status, length of stay, condition of treatment, confidentiality of records and the various types of releases from a psychiatric hospital.

The role of the advisory board in protecting patients' rights while hospitalized was discussed. This involves a shared role with the Legal Aid Society, however, if certain patterns of abuse continued, the advisory board should make the administration aware of this community problem.

The trainer brought to the session the paperback, Rights of Mental Patients, which was distributed to the group. The chairperson brought to the meeting (without the

trainer's previous knowledge) a statement of a bill of rights for patients prepared by the Joint Commission On Accreditation of Hospitals. This was viewed as a display of positive interest on the part of the Chairperson.

Initially, a summation of the training sessions was planned for this meeting. Eight members were present. One person had attended all six sessions. One person attended five of the six sessions. Four were attending for the fourth time, one attending for the third time, and one attending for the first time. The post questionnaire was distributed to the group. All of them filled it out during the session. Several voiced their feeling that the training had been helpful and had given them a better perspective of their role as advisory board members. The trainer informed the group that he would be available to follow-up on any issues in subsequent meetings and that the training sessions also had been a learning experience for him.

Limitations of Training

As a result of these training sessions, several limitations became apparent in the process of training consumer advisory boards to mental health facilities. The chief limitations are:

1. Membership on these boards reflects a wide range of educational backgrounds which hinders the training processes. With such a wide range of educational backgrounds, the ability

of the group to relate to various concepts, their range of interest, their attention span, their retentive abilities, varies considerably. It becomes difficult to establish a common vocabulary as Greer recommended.¹

2. Due to the nature of a community mental health center's program, the training program cannot be geared to the time phases of the Center. Formulation of the budget occurs once a year, programmatic audits may occur at any time during the year, any crisis may occur which will direct the resources of the Center to concentrate on the particular issue. Hence, the retentive abilities and the stability of the group becomes crucial in this type of training. The use of outlines, pamphlets and resource material can be helpful in partially overcoming this problem.
3. The advisory board meetings occur once a month which creates major problems in conducting the training sessions and introduces several intervening variables in attempting to research findings as attendance varies.
4. Role relationships within a group which has been meeting regularly have been formed. The addition of the trainer may be a threat to

some of these role relationships. This statement proved accurate during this training program. One member of the group had considerably more formal education than the other members. She had assumed the role of "expert" and final authority on most matters discussed in the group. The author was viewed as a threat to her role position. Initially, she attempted to belittle the trainer but she became less so as the trainer solicited her participation in the process. However any trainer of consumer advisory boards should be cognizant of this potential role threat emanating from the training process.

Other limitations of the training process will be discussed in Chapter VI.

FOOTNOTES

1. Ann L. Greer, "Training Board Members of Health Planning Agencies," Public Administration 91 (January-February 1976) : 61.

CHAPTER V

ANALYSIS OF THE DATA

Introduction

This chapter is divided into two main sections. The first section relates to the degree of equivalence between the experimental group and the comparison group based upon age, sex, education, length of residency in the community, occupation, social class and time on the advisory board. Based upon this comparison, a descriptive summary will follow indicating the author's perception of any differences between the two groups.

The second section of this chapter is concerned primarily with testing the propositional statements presented in Chapter IV, employing the statistical methodology elicited under the section on program evaluation. This will involve a statement of the two propositional statements and how content analysis of the minutes was used to measure the findings of this study. This will be further delineated in the second section of this chapter.

Characteristics of the Experimental Group
Age, Sex, Education, Time on Board,
Length of Residency, Occupation and Social Class

Ten subjects of the experimental group completed the pre questionnaire, hence, characteristics of this group cannot be extended to the entire advisory board. In all, 17 different people attended the training sessions. The breakdown of the participants in the six training sessions is as follows:

	<u>Number of Participants</u>
Session I:	10
Session II:	12 - eight attending for the second time and four attending for the first time.
Session III:	7 - four attending for the third time and three attending for the second time.
Session IV:	7 - four attending for the fourth time, two attending for the third time and one attending for the first time.
Session V:	9 - two attending for the fifth time, one attending for the fourth time, three attending for the third time, one attending for the second time and two attending for the first time.
Session VI:	8 - one attending for the sixth time, one attending for the fifth time, four attending for the fourth time, one attending for the third time and one attending for the first time.

A total of six members attended four or more sessions.

The total board membership consisted of 25 names but attendance was sporadic. A review of the board's attendance six months before the training indicated a similar attendance pattern. The training itself did not appear to affect attendance. Higher attendance appeared to be related to potential crises for the mental health center such as a proposed reduction in funding. The post questionnaire was given to those who attended any of the sessions. Greater importance in the descriptive interviews was placed on those who attended the most sessions. Of the ten members who filled out the pre questionnaire, seven attended three or more sessions.

Consumer Membership on Board

Based on the ten board members who filled out the pre questionnaire, six proved to be "consumers", that is, they were residents of the community mental health center's catchment area and were not employees of the institution. They were not consumers in the usual use of the word, that is, someone who uses the services of the institution, with the exception of one person. That person indicated that she had used the services of the mental health center but did not state which service or when she had used the service.

The other four people who filled out the pre questionnaire were all employees of the center. One was a psychiatrist who resided within the catchment area of the

mental health center, two were clinic directors of storefronts of the center and one was a mental health worker who was employed at one of the storefronts.

Since the board's membership consisted of 25 people, it is not known if the other 15 were true consumers of the center. In informal discussions during the training sessions, the author learned that several of them were employees of the center's storefronts. It appears that a majority of the total board's membership were not true consumers but rather employees of the institution.

Other demographic data based on the pre questionnaire are as follows:

Time on Board

Four members had been on the board for 13 years or since the inception of the advisory board, one member had been on the board for the past 10 years, and the others ranged from three years to attending for the first time, producing a mean of 5.9 years with a standard deviation of 5.5. The five members who had attended for 10 or more years were the consumer members of the board.

Time in Community

Most of the board members had been residents of their local community for several years. The range was from 30 years to 8 years with two members not residents of the community, producing a mean of 19.1 years and a standard deviation of 9.3. Again, those who were the true consumers on the board had the longest residency in the community.

Sex

Eight of the ten were women.

Occupation

Of the ten respondents, two were retired, one was a housewife, one a secretary, one a psychiatrist, two were mental health workers, two were clinic directors and one, a student. Again, most of the true consumers listed their occupation as "housewife." Whether they were retired to the role of housewife or had been housewives primarily for several years is unknown.

Education

The group ranged from one member who was an M.D. to one member who had an eighth grade education. The mean was 15.1 years of formal education with a standard deviation of 3.6. Those who were true consumer members of the board had less education than the other members.

Social Class

All of the respondents to the pre questionnaire felt the other board members were middle-class. A cross check with listings of occupation tended to confirm this statement.

Age

The range of the ages was from 37 to 65. The mean age was 50 with a standard direction of 8.9.

The above data are summarized in Table I.

TABLE I

SUMMARIZED DEMOGRAPHIC DATA
OF EXPERIMENTAL GROUP

<u>Variable</u>	<u>Mean</u>	<u>Standard Deviation</u>
Time on Board:	5.9 years	5.5
Time In Community:	19.1 years	9.3
Sex:	(80% female)	(20% male)
Education:	15 years	3.6
Age:	50 years	8.9
Social Class:	(mode-middle class)	
Occupation:	Retired-2	
	Housewife-1	
	Secretary-1	
	Psychiatrist-1	
	Mental Health Workers-2	
	Clinic Director-2	
	Student-1	

Authority of the Community Advisory BoardBased upon the Pre Questionnaire

The pre questionnaire elicited responses as to the degree of authority of the advisory board. The range was:

1. Has Control - the Center asks the board to identify some problems, make the key decisions regarding goals and means, and the board has administrative control over the unit
2. Has Delegated Authority - the Center presents a plan to the board and asks the board to make a series of decisions which can be embodied in the plan
3. Plans Jointly - the Center presents a tentative plan to the board, subject to change and invites recommendations from the board
4. Advises - the Center presents a plan and invites questions from the board
5. Is Consulted - the Center develops a plan and seeks the support of the board
6. Receives Information - the Center develops a plan and announces it to the board
7. None - the board is told nothing about some aspects of the program

For each category the board members were asked to check whether they "strongly agreed" with the statement, "agreed" with the statement or "disagreed" with the statement. One person indicated that the board had control

in the board's working relationship with the mental health facility. He marked, "agree." Four members indicated the board had delegated authority. Three marked "agree" and one marked, "strongly agree." Four members indicated the board plans jointly, all three marking, "strongly agree." One person marked advises and also marked, "strongly agree." None of the other categories were marked. For the vast majority of the group, their working relationship with the center consisted of exercising delegated authority and planning jointly with the Center.

A review of the board's minutes six months before the training indicated that the board made recommendations regarding administrative proposals (Plans Jointly) in the majority of instances and on a few occasions the Center presented a plan to the board and elicited questions concerning the plan (advises). This is in conformity with five of the ten responses. The minutes did not reveal any instance of the board exercising delegated authority even though four members of the group indicated so.

Relationship with the Center's

Board of Directors

A wide range of answers was given to this question. One person said "yes", two people said "no", one person stated, "not sure", and three people stated that the executive committee had contact with the Center's Board of Directors. Three members did not respond to the question. The question asked them to describe their relationship with

the board. Except for three people who indicated that the executive committee met with the board, none of the other members commented on their answer.

Generally, the board members were uncertain of their relationship with the Center's Board of Directors. A review of the minutes six months before training revealed that none of the board members had any contact with the Center's Board of Directors. This was also true during the training sessions and for a six month period following the training.

Other Characteristics of the Board
Based on the Pre Questionnaire

Other questions contained in the pre questionnaire related to their knowledge of the board processes and their motivation for membership on the board. Most of the respondents indicated they initially joined the board to establish a community mental health center or to help others. Four indicated their membership was based on their belief in consumer participation. Only one of the ten respondents indicated they had personally used the services of the Center.

Five of the respondents indicated that they were members of other civic groups in the community. Three were members of tenant organizations and two stated they were members of "civic" organizations. Only one respondent listed her responsibilities as a board member to act as liaison with these other organizations. Most of the respondents indicated their responsibilities as "supportive"

of the program or Director.

When asked about the personal benefits of advisory board membership, most related to their increased ability to help others by participation and their increased knowledge of the program's services.

The three main categories of response to the question of "the benefits to the program by their participation in it" consisted of their role in securing funds for the program, referring patients to the Center, and sharing information with the group after attending conferences.

Under the section "other comments", three board members responded. One stated, "we need more people to get involved." Another one stated, "as a provider who does not reside in area, I am non-voting." The other responded, "I have been interested in the development of Community Mental Health Centers since about 1963. I am somewhat disappointed in the movement to the extent that it is represented by this C.M.H.C. There is still a dual system of mental health services, and professional integrity are[sic] often more important than consumer interests in mental health planning, as has always been the case." The extent to which these remarks are indicative of the members of the total advisory board is unknown.

Characteristics of the Comparison Group :

Age, Sex, Education, Time on Board

Length of Residency, Occupation and Social Class

The comparison group was located in the same city as the experimental group. Like the experimental group, they were all lay members of a consumer advisory board to a community mental health center. The same requirements for membership existed for this body as existed for the experimental group. This group was studied during the exact same time frame as the experimental group.

Unlike the experimental group, this body represented a different ethnic composition. The catchment area of the comparison group consisted mainly of Jewish residents, then a large segment of Italians and an increasing number of Hispanic people. This division also produced different religious affiliations. Unlike the experimental group, few Blacks resided in its catchment area.

During the sessions the trainer attended of the comparison group, between twenty and twenty five members were present. Like the experimental group, the pre questionnaire was distributed to them. Of the 20 members who were present at this session, all completed the questionnaire and returned it to the trainer during this initial session, which differed from the experimental group. The chief demographic characteristics of the comparison group are presented in Table 2.

TABLE 2

SUMMARIZED DEMOGRAPHIC DATA OF COMPARISON GROUP

<u>Variable</u>	<u>Mean</u>	<u>Standard Deviation</u>
Time on Board:	3.4 years	2.5
Time in Community:	23.6 years	12.7
Sex:	(30% females)	(70% males)
Education:	14.1	2.7
Age:	48	11.7
Social Class:	(mode-middle class)	
Occupation:	Teacher - 3	
	Social Worker-4	
	Businessman-10	
	Bookkeeper-1	
	Legal Secretary-1	
	BusDriver-1	

Consumer Membership on Board

As the trainer was not involved on an ongoing basis with the comparison group, the number of true consumers on this board is unknown. All of the respondents stated on the pre questionnaire that they resided in the catchment area of the Center which is a necessary condition of consumer membership. In one of the sessions following the training of the experimental group, it was revealed that a member's wife was an employee of the Center. The issue arose as to whether he could remain on the advisory board. Since this issue arose concerning one member only, there exists the possibility that the other board members were not employees of the institution.

Two respondents indicated that they personally or their families had used the services of the community mental health center. This compared to one respondent in the experimental group whose family had used the services of the Center. However, in both instances, the figure is low.

Authority of the Community Board

Based Upon the Pre Questionnaire

There was strong internal disagreement as to their degree of authority with the mental health center. Nine indicated that the board has control over some issues while three felt the board possesses delegated authority. Five felt the board plans jointly with the Center and three indicated the board advises.

A review of their minutes six month's prior to training indicates that most interactions fell within the plans jointly category and advises which is similar to the experimental group.

Relationship with the Center's

Board of Directors

All but three respondents stated that there was no ongoing contact with the Board of Directors. Two stated that there were intergroup meetings and one stated there was regular contact.

This differs markedly from the experimental group who seemed confused as to the advisory board's contact with their Board of Directors.

Other Characteristics of the Comparison Group
Based on the Pre Questionnaire

Like the experimental group, most of the comparison group indicated their motivation for advisory board membership consisted of their interest in serving the community and consisted of their interest in mental health. Two of the respondents indicated that their children motivated them to join but did not elaborate on this. One person stated their husband motivated the person to join but, again, did not elaborate.

Unlike the experimental group, most of the members were involved with other organizations in the community, mainly church, school, and other civic programs. (Only 50% of the experimental group members were so involved.) Only two members of the comparison group did not respond to this question. All others were active members of other civic groups. Like the experimental group, only one member stated a liaison role between these civic groups and the advisory board. Apparently, their membership in other civic groups has been independent of their role as advisory board members to a community mental health center. Most respondents to the question relating to their responsibilities as a board member viewed the question in concrete terms. They related to their membership on subcommittees of the advisory board or global statements such as, "to serve the community." Two respondents stated their responsibilities as to critically evaluate the program and the delivery of mental health

services, recommend changes or improvements, and seek additional mental health services for their community. However, these responses were the exception.

Like the experimental group, most of the members related to their increased knowledge of the program and increased ability to help others as the main personal benefit resulting from advisory board membership. Four did not respond to the question and one response consisted of "none."

Of those that responded, most related to their ability to provide community input as the major benefit to the program by their participation, which response was similar to the experimental group.

Three members responded to the question, "other comments." One responded, "I believe in helping others - this organization gives me the opportunity." Another responded, "we really have had made a positive input on the center, its operation and mental health to the community." The other response was, "I wish the professional staff was more open and honest with the board. I feel that they use the board and only tolerate us because they are required to have a community board. There is always a feeling from the professionals that we have no value. It is sad because working together we could achieve much more for everyone. I am disappointed by this attitude." The extent to which these remarks are indicative of the members of the total advisory board is unknown.

This last response relates to some of the crucial issues of community advisory board membership. Central to the meaningfulness of the consumer advisory board concept is the relationship between the advisory board and the professional staff of the center. If the board is "tolerated" and "used" then the process becomes meaningless. Just as a lay advisory board requires training, by the same token, the professional staff of the Center may need training in the potential benefits to them of a community advisory board.

Demographic Characteristics of the Experimental Group and the Comparison Group

In this section the experimental group and the comparison group will be examined in terms of their similarities and differences based upon the demographic data of age, sex, education, length of board membership, length of residency in their community, occupation, and social class. Inferences which can be drawn from this data will be stated.

Although located in two different geographical locations of the city and with different ethnic compositions, there was a close similarity in the ages of the experimental group and the comparison group. The mean age of the experimental group was 50 with a standard deviation of 8.9 and the mean age of the comparison group was 4.8 with a standard deviation of 11. Hence, in the category of age, the experimental group and the comparison

group achieve strong equivalence.

The close similarity between the ages of the two groups may reflect that older, more established people become interested in consumer board membership to mental health agencies. Or, it may reflect that the mental health agencies seek out older, more established people in their communities as consumers to their mental health advisory board. It is beyond the scope of this project to explore this issue and since this project involved only two mental health advisory boards, no generalizations are possible.

Of the ten members of the experimental group who completed the pre questionnaire, eight were females (80%) and two were males (20%). The sexual composition of the entire 25 board members is unknown. A total of 17 different people attended the training sessions. Of these additional seven who did not fill out the pre questionnaire, five were male and two were female. In the comparison group, seven members were female (30%) and fourteen members were male (70%). Of the total 17 members of the experimental group who attended the training sessions, ten were female (59%) and seven were male (41%). Hence, the two groups did not approximate equivalence on this variable.

There existed close similarity between the

experimental group and the control group in respect to the formal education of the two groups. The mean of the experimental group was 15.1 years of formal education (a little over three years of college) with a standard deviation of 3.6. The mean of the comparison group was 14.1 years of formal education (a little over two years of college) with a standard deviation of 2.7. Also the range of the experimental group was between one eighth grade graduate to one person who possessed an M.D. degree. This was close to the range of the comparison group which ranged between one person who had a tenth grade education to one person who was a doctoral candidate.

In general, the formal education of the two groups was very similar indicating an average education of two years of college for the board members. This correlates with their occupations and social class affiliation.

The length of time the respective members had served on their advisory boards differed between the experimental and comparison group. Five members of the experimental group had been board members since the inception of the advisory board. This constituted 50% of the experimental group who responded to the pre questionnaire. The mean length of board membership for the experimental group was 5.9 years with a standard deviation of 5.5. The fact that the mean length of board membership was 5.9 years reflects the fact that the other five members had been board members for a short period of time. For the

comparison group, the mean length of time on the board was 3.4 years with a standard deviation of 2.5.

The experimental group and the comparison group did not approximate equivalence in regards to length of board membership. This is viewed as mainly due to the skewed range of the experimental group and the fact that the sample of the experimental group members consisted only of ten members.

There existed close similarity between the length of residency in the community for the experimental group and the control group. The mean length of residency for the experimental group was 19.1 years with a standard deviation of 9.3. For the comparison group the mean length of residency was 23.6 years with a standard deviation of 12.7. Both group's means, however, contained high standard deviations, indicating a wide range within each group. The range for the experimental group was from seven years residency to 30 years residency. With such a low sample (10) this would produce a high standard deviation. The range for the comparison group was from 55 years residency to two years residency. Again, a wide range was present which would account for a high standard deviation.

Occupationally, both groups consisted mainly of lower middle class membership. This correlated with their educational background and social class positions. The two groups approximated equivalency in respect to this variable.

Finally, in terms of social class, the two groups were similar. It is postulated that membership on civic organizations such as advisory boards to mental health facilities would attract socially mobile members of the middle class.

In summary, equivalence was approximated between the experimental group and the control group in terms of the variables of age, length of residency in their respective communities, occupation, formal education, and social class affiliation. Major differences existed between the two boards in terms of sex, ethnic composition, and length of board membership.

Following is Table 3, providing a breakdown of these variables between the experimental group and the comparison group which is provided for comparison purposes.

TABLE 3

COMPARISON OF THE DEMOGRAPHIC CHARACTERISTICS OF THE
EXPERIMENTAL GROUP AND THE COMPARISON GROUP

<u>EXPERIMENTAL GROUP</u>			<u>COMPARISON GROUP</u>		
	<u>Mean</u>	<u>Standard Deviation</u>	<u>Mean</u>	<u>Standard Deviation</u>	
Age:	50 years	8.9	48.0	11.7	
Sex: (80% Female; 20% Male)			(70% Male; 30% Female)		
Time on Board:	5.9 years	5.5	3.4	2.5	
Time In Community:	19.1 years	9.3	23.6	12.7	
Occupation: (Mode-Middle Class)			(Mode-Middle Class)		146
Education:	15.1 years	3.6	14.1 years	2.7	
Social Class:	Middle Class		Middle Class		

Testing of the Study's Propositional Statements

This section of the chapter relates primarily to testing the propositional statements of this project. The propositional statements, the statistical methodology for measuring them, and the findings will be presented in this section.

The Program Design

The overall goal of this project is to improve the delivery of mental health services to a targeted population.

The following objectives of the program to be measured in achieving this goal are:

1. To increase the board's understanding
of their role, function and responsibilities
which will be reflected in an increase in the
number and types of the board's activities
2. To improve communication between the board
and the administration of the Center
3. To increase provider responsiveness to the
concerns of the board

To operationalize these objectives the following major substantive propositional statements of this demonstration project have been formulated.

If the advisory board of a mental health center receives a training program which clarifies their role and activities and educates them in the mental health service delivery system, organizational processes and group decision

making processes, then higher levels of consumer participation will occur.

This propositional statement is based on the rationale that consumer advisory boards function more effectively when they receive formal training concerning their role within the organizational matrix and the mental health delivery system.

This proposition contains two key variables. The training program is the independent variable of this proposition. It is operationalized to mean the contents of the training sessions as contained in Appendix B. The major dependent variable is "higher levels of consumer participation." It was operationalized to mean a change in the number of activities performed by the advisory board and by changes in the types of the advisory board's activities. This will be measured by a content analysis of the board's minutes using a before-after study.

It was also measured by conducting personal interviews with the board members following completion of the training sessions. This will broaden the evaluative component of the study by obtaining a descriptive analysis of the board members perception of increased participation in the meetings.

The second major propositional statement of the demonstration project is:

If the advisory board of a mental health center receives such a training program, then substantive changes

will occur in the relationship between the advisory board and the administration of the Center. The dependent variable "substantive change" will be operationalized to mean non procedural changes in the relationship as measured by a content analysis of the advisory board's minutes. Again, personal interviews with the board members will be used also to obtain a descriptive analysis of the change or lack of it.

To test these propositions, the author initially planned to use the model of quasi or compromise experimental group-control group design. Since randomization was impossible in this study, equivalence of the two groups was approximated by testing the similarity of the two groups in the pretest for such relevant factors as age, sex, education, occupation, and social class. The means of the two groups and the standard deviation would be used to determine the extent of similarity of the two groups.

While this analysis will be performed, it should be kept in mind that, in actuality, the control group was a non equivalent one and, hence, the design was a comparison group design. The experimental group and the control group are similar in that both are community advisory board's to a community mental health center.

Evaluation

To measure the propositional statements contained in this project, the methodology of content analysis was

employed. The data source for this analysis will consist primarily of the board's minutes (prior to training, during training, and immediately following training). In addition, correspondence to and from the administration of the Center will be analyzed. However, since the data source, in part, is from institutional records, there exists the possibility that omissions of material is present and the written material may be tainted.

This approach was considered superior to a study of their perceptions of the training sessions. Typically, studies of consumers' perception of training programs has been the methodology of choice when studying consumer participation.¹ Such studies tend to focus primarily on the consumers' perception of involvement in the decision making process rather than on measuring the substantive impact of such participation on the target organization. Studies of consumers' perceptions are basically subjective, interpretive reports, and more important, essentially are not replicable. Many of these studies use different data collection techniques which make comparison across studies relatively unreliable and makes it difficult to measure outcome.

"Content analysis is a technique for the systematic description of the manifest content of communication that replaces direct observation of behavior with observation of formal communications that take place as a by-product of a specific type of behavior."² It is a

methodology for observing and measuring variables and, hence, can be used to test hypotheses.

To measure the dependent variable "significantly higher level of consumer participation", content analysis will be used to measure activity of the board along two dimensions:

- a. number of activities (increase or decrease)
- b. types of activities (increase or decrease)

The division of types of activities (and a weighing system for them since not all activities are of equal importance) will use the system developed by Metsch and Veney, which has been field tested.³ This schema differentiates among eight, exhaustive, mutually exclusive categories, that describe the board's activities and administration's activities.

The eight categories are:

1. The board requests a change in hospital policy requiring an allocation of services (e.g. initiate a new program, hire new personnel, improve an existing service)
2. The board requests information within the organization (e.g., provide information on manpower or financial data); on a program; investigate complaints; provide workload
3. The board requests information not within the organization (e.g. provide information on a community agency's program)

4. The board requests support for an external program (e.g. provide medical support for a local drug program)
5. The board requests the Center to provide tangible support to the board (e.g. pay expenses so the members can attend meetings)
6. The board requests a support service on behalf of the board (e.g. write a letter to a legislator, provide stationary for the board, prepare an informational brochure)
7. The board requests a change that does not require an allocation of resources (e.g. install a complaint box in the clinic, install bilingual signs in the emergency room)
8. The board requests the Center to conduct a feasibility study on a committee proposal that involves a potential allocation of resources (e.g. study the feasibility of a mobile clinic)

Prior to the training, the minutes of the board were tabulated to determine the number and type of each activity. This will be compared to the minutes following completion of training (a six month period before and after will be used for the experimental and control groups). A chart giving the results was tabulated.

As stated, not every activity is of equal importance. To adjust for these differences, a weighing

system was developed by a team of fifty judges who weighed the categories in terms of "consumer activities" and fifty other judges who weighed the categories as "administrative actions." This was part of the Metsch and Veney study previously noted. Such a ranking seems reasonable for the purpose of this project which also studies the effects of training sessions to the advisory board of mental health facilities.

The categories will be ranked as follows for measuring advisory board activities:

<u>Rank</u>	<u>Category</u>	<u>Median</u>
1	1 - change in hosp. policy	8.81
2	8 - request a potential allocation of resources	8.85
3	4 - request support for an external program	7.55
4	3 - request for external information	7.38
5	7 - request a change not requiring an allocation of resources	7.18
6	2 - request for internal information	6.70
7	5 - request support for the board	6.11
8	6 - request a support service on behalf of the board	5.98

The median represents the average score the fifty judges ascribed to the relative importance of each category.

The eight categories also were ranked by another team of fifty judges to determine their significance as observations of administrative response. Their ranking is:

<u>Rank</u>	<u>Category</u>	<u>Median</u>
1	1	8.76
2	4	8.24
3	8	7.76
4	5	6.50
5	2	5.91
6	7	5.79
7	3	5.73
8	6	4.35

The rationale for these weighings consisted of the logical patterns which they revealed and the expertise of the one hundred judges. For consumer input, those items ranked first and second (categories 1 and 8) relate to change in the mental health care delivery system. Items ranked third and fourth (categories 4 and 3) represent an outward focus, looking beyond the immediate mental health center. Items ranked fifth and sixth (categories 7 and 2) have an internal focus, while those ranked seventh and eighth (categories 5 and 6) relate to board operations in particular and only peripherally to the objectives of promoting better delivery of mental health services. Or, in another way of stating it, those rated of higher significance as compared to those rated of lower significance represent:

1. Proposed major change in the policies and organizational structure of the Center.
2. Focus on the suprasystem of the mental health field.
3. An immediate focus upon the board's activities.

For administrative response, the weighings also appear logical as they represent a high to low commitment of the resources of the organization. Items ranked first and second (categories 1 and 4) indicate clear resource allocations. The third item (category 8) represents a potentially sizeable expenditure. The fourth ranked item (category 5) indicates a lesser allocation, but nevertheless, a commitment to spend. The one ranked fifth (category 2) while not a commitment of resources, may make it necessary to disclose the extent of available resources and be a stimulus to increased activity in items ranked first to fourth. Items ranked sixth, seventh, and eighth (categories 7, 3, and 6 respectively) represent little or no cost to the organization.

The measurement of the first proposition's dependent variable "significantly higher level of consumer participation" is divided into two separate typologies. The first relates to the frequency of activities. Content analysis will be used of the board's minutes (on a before-after basis) to determine the frequency. A change in topic area will signal the start of a new activity. These activities will be coded and summed. The percentages will be tabulated compared to before and after the training sessions. Since this is an interval measurement, their means and corresponding standard deviations will be tabulated, a correlation of coefficient will be determined between the data of the two groups and tests of significance

will be employed to determine success/failure criteria.

The second part of the first proposition relates to the measurement of the types of activities of the board. Content analysis of this board's minutes (on a before-after basis) will be used to record each observation which will be coded into one of the eight categories and the proper weight of that observation will be recorded.

As an example:

<u>COLUMN A</u>	<u>COLUMN B</u>	<u>COLUMN C</u>	<u>COLUMN D</u>
<u>Activity</u>	<u>Category</u>	<u>Consumer Input Weight</u>	<u>Administrative Action Weight</u>
1. Obtain Center's annual report.	2	6.70	5.91
2. Obtain information on a community program.	3	7.38	5.73
3. Prepare informational brochure on an out-patient program.	6	5.98	4.35
4. Provide stationary to board	6	<u>5.98</u>	<u>4.35</u>
		*26.04	**20.34
* Consumer Input Score			
**Administrative Action Score			

The weights derived are summed to generate a consumer input score and administrative action score. Each observation (Column A) is first assigned to one of the generic categories through defining its consumer input weight. If the providers respond to the activity of the consumer input, the appropriate administrative action weight for the category is assigned as well (column B). This will generate a total consumer input score (based on the number

of such activities and their relative weight) and an administrative response score (based on number of activities and their relative weight). These will be summed and compared on a "before-after" basis between the experimental group and the control group. Their means and corresponding standard deviations will be compared, a correlation coefficient will be determined between the data of the two groups and tests of significance will be employed to determine success/failure criteria.

To measure the second proposition's dependent variable, "substantive changes between the advisory board and administration", the first four rankings will refer to substantive changes, and the last four categories will relate to procedural changes. Again, content analysis of the minutes will be used on a "before-after" basis to record each observation of the board and the administrative response to code the activity into the proper category. The results will be compared between the experimental group and the control group. Since this is an interval measurement, the tabulation noted above for interval changes will be performed.

Findings Relevant to the First Propositional Statement

The first propositional statement reads, "if the advisory board of a mental health center receives a training program which clarifies their role and activities and

educates them in the mental health service delivery system, then higher levels of consumer participation will occur."

The proposition contains two main variables. The training program is the independent variable of this proposition. It was operationalized to mean the contents of the training sessions. The major dependent variable is "higher levels of consumer participation." It was operationalized along two dimensions:

1. A change in the number (frequency) of interactions between the board and the administration of the Center
2. A substantive change in the type of the board's activities in relationship to the administration of the Center and a substantive change in the type of activities of the administration towards the consumers on the advisory board

To measure the change in the number of activities, the design developed by Metsch and Veney was employed.⁴ This involved the use of their consumer/provider interaction score. Prior to the training, the minutes of the previous six sessions were examined and codified to produce a consumer/provider interaction score. Each observation in the minutes was first identified as either interaction/integration or as direction/control. An observation was coded as interaction/integration if the observation was consumer initiated while the direction

control code was applied if the observation was initiated by a provider representative to the advisory board. As an example, while an unrequested session for consumer education was coded direction/control, consumer education in response to a request from the consumer board members is interaction/integration. Initiation of a topic by a provider representative is direction/control, follow-up by consumer representatives in the form of discussion and/or a recommendation at a later time is interaction/integration. A change in topic area signaled the start of a new observation.

The comparison of the consumer/provider interaction score consisted of coding the minutes of the board sessions for a six month period before the training sessions and for a six month period following the training sessions. Since the trainer was not present at the board meetings prior to the training, only the recorded minutes could be used for analyzing the data. However, the trainer was present at the board meetings for a six month period following the training sessions. This data results both from recording the data from the minutes and from recording the data from the trainer's notes of the six sessions. Differences occurred only in two instances, hence, from the data it does not appear that the trainer's presence in recording the sessions constitutes a major variable in the analysis of the data.

Introduction

For the six month period of time prior to the training, the minutes of these meetings were subjected to content analysis to produce interaction/integration scores and direction/control scores. These will be summed to produce a total interaction/integration score and a total direction/control score. This score will be compared with the interaction/integration and direction/control scores following training to determine if an increase or decrease in the number of activities occurred and whether these activities were consumer initiated or initiated by the administration.

Sixth Session Prior to Training : September, 1981Experimental Group - Interaction/Control Scores

The Chairperson of the consumer advisory board raised the question to the professional staff present of how patients can reach their therapist after 5:00 p.m. if an emergency arises. She stated that she had received complaints that patients had called and could not reach their therapist (as this topic was consumer initiated, it was scored as interaction/integration).

The Director of the Community Mental Health Center indicated that staff is available to take such calls after hours but it may not be the patient's actual therapist. Emergency care is provided on a 24 hour basis at the facility, he said (this was scored direction/control).

One of the professionals of the Center mentioned the drop in census at the outpatient clinic of the Center. She elicited discussions from the advisory board as to the causes and remedies for this drop in census (scored as direction/control). This elicited discussion among the advisory board members. The consensus of the board was that the double bus fare required to reach the Center was a primary contributing factor. It was felt that many patients could not afford this double fare each way and dropped out of treatment (scored interaction/integration). Continued discussions by the advisory board members led to the conclusion that another satellite clinic of the Center was needed; one that would be centrally located and one that would not require a double fare for the residents of the community (scored interaction/integration). The Director responded to this by appointing his Chief of Social Service to investigate possible space in the community for such a clinic (scored direction/control).

The Director informed the advisory board of an eight session workshop to be held at the Center on the topic of "Money Problems and Stress: What to do About it."

At the end of this first session of tabulating the consumer/provider interaction score the results were:

interaction/integration: 3,

direction/control : 3

Fifth Session Prior to Training - October, 1981

As occurred during the previous session, the Chairperson of the advisory board raised the issue of therapist availability on a 24 hour basis. One of the professional staff of the Center stated that many patients had been given their therapists's home telephone number if an emergency arises. He added that it isn't always possible to reach a specific therapist after hours seven days a week but the Emergency Room is always open and a psychiatrist is on call at all times (since this issue was discussed in the previous session and given a consumer/provider interaction score, it was not scored again).

One of the advisory board members then recommended that patient charts be kept in the Emergency Room on off-hours so that the person who takes a patient call would be knowledgeable about the case. Following discussion, the board members made this recommendation to the Center (scored as interaction/integration). The Director of the Community Mental Health Center and one of the professional staff present at the meeting stated patient charts are not kept in the Emergency Room due to the patient's rights to confidentiality. However, they did propose that a central registry of patients might be possible (scored direction/control). They noted that regular in service training is conducted with the staff in the emergency room.

One of the professional staff members present

indicated that the number of new admissions was decreasing during the summer months and elicited recommendations from the advisory board members (since provider initiated, scored direction/control). Some of the board members felt the decline may be due to school closings in the summer months which is an important source of referrals. Discussion on the topic continued and several board members recommended ways to publicize the services of the Center such as Public Service announcements, write-ups in local newspapers, an "open house", and posters advertising the services of the Center (as consumer initiated, scored interaction/integration). The Chairperson of the board noted that community organizations are not relating information in their newsletters regarding the services of the Center regardless of how many articles written and submitted.

The Director of the Center informed the group of the date and time of a meeting of the National Council of Community Mental Health Centers. Board members were urged to attend this meeting (scored, direction/control).

The Chairperson of the advisory board stated that she would send letters on behalf of the advisory board to State officials to reaffirm their commitment to community advisory boards (scored, interaction/integration).

The Chief of Social Work Services stated that she has been seeking space in the community for an additional satellite clinic. (This was a follow-up from the

previous meeting.) She reported that potential space is available at a local church and she met with one of the church officials. She has sent letters to the pastor of the church but no response has been received as of now (scored direction /control).

The Director of the Center reported on the new "block grants" legislation wherein the state will determine the allocation of funds to the community mental health centers. He noted that this new federal legislation does not mention the need for consumer advisory boards and urged the board to submit letters to the State urging their commitment to local consumer advisory boards (scored direction/control).

The Director also informed the group that the electricity on the fourth floor which houses the inpatient unit is still inadequate. As a result, admissions have been curtailed and he urged the board not to publicize this service of the Center in the community (scored, direction/control).

At the end of this second session of tabulating the consumer/provider interaction score the results were for this session:

interaction/integration : 3

direction/control : 5

Fourth Session Prior to Training : November, 1981

One of the professional staff members who is the

head of the advisory board's Review Committee noted that admissions to the Adult Outpatient Clinic were higher in September, 1981 but were lower than for the same period in 1980. She elicited response from the advisory board members as to the causes for this (scored, direction/control). Some of the board members felt that many people in the community still view "mental health" as a stigma and hesitate to seek such service. Discussion pursued on this topic but no formal recommendations ensued.

The membership committee reported that membership letters had been sent during the past months but very few responses occurred. The group suggested that new organizations be contacted for membership such as the NAACP, the Urban League and local community boards. It was also suggested that families of former patients and former patients be contacted to serve on the advisory board (as consumer initiated, scored interaction/integration). The professional staff present indicated select former patients could attend the meetings as consumer participants (scored direction/control).

The Director of the Community Mental Health Center requested the board members to send letters to the Governor and mental health legislators to provide additional funding to the Center for additional mental health services for the aged in their catchment area. The Director indicated the possibility of securing funds for this specific population (scored, direction/control).

The Director announced the date, place, and time of a Health Fair to be held at the mental health center. All board members were urged to attend (scored, direction/control).

The Director reported on the Center's volunteer program. He informed the group that besides the services such people provide to the Center, it also serves as a valuable training program for them. He urged the board members to explain this program to interested people in the community (scored, direction, control).

The Director also reported that he met with the Assistant Director of the Department of Psychiatry to discuss the issue of client ability to reach therapists when the clinic is closed. This Assistant Director has responsibility for the professional services in the Department of Psychiatry's Outpatient Clinics and in the Emergency Room. He informed the Director of the Mental Health Center that their policy is not to provide the therapists' home telephone number except when necessary in the judgment of the therapist. If patients of the Center require emergency help they may contact the Emergency Room. The Assistant Director of the Department of Psychiatry indicated that many of the therapists do not have private services or phone recordings and, hence, the possibility of reaching them at off hours would be difficult. (Since this follow-up was provider initiated, it was scored, direction/control.)

At the end of this third session of tabulating the consumer/provider interaction score, the results for this session were:

interaction/integration : 1

direction/control : 5

Third Session Prior to Training
December, 1981

The Director of the Community Mental Health Center noted that the inpatient unit is fully operational now. He mentioned that in the past the advisory board had raised the issue of how it would relate to the new inpatient unit. Since the unit is now operational, he felt the board may want to explore the ways in which it will relate to the unit. (The minutes do not contain any response from the board members concerning this issue.) Since this interaction between the provider and the consumer board members was initiated by the providers, it was scored direction/control.

The Director informed the group of a pending meeting with select State legislators concerning the need for additional funding for mental health programs for the pending fiscal year. The time and location of this meeting was provided to the group. All advisory board members were strongly urged to attend and participate in this meeting (scored, direction/control).

The Director of the Center informed the group of a

study performed by the Center. It gathered programmatic data and statistical data on the services of other mental health providers physically located in and serving the Center's catchment area. This information was read to the group. The Director urged the consumers to be aware of these other services when planning additional programs for the Community Mental Health Center (scored, direction/control).

At the end of this fourth session of tabulating the consumer/provider interaction score, the results for this session were:

interaction/integration - 0

direction/control - 3

Second Session Prior to Training - January, 1982

The Director distributed copies of the Center's Annual Evaluation Report. It will be discussed at the next meeting.

One of the professional staff members of the Review Committee attended the meeting with State Legislators and advisory board members. (This meeting was announced at the last advisory board meeting.) A nine point position paper was adopted and distributed to the board members. She urged the board members to adopt these resolutions (scored, direction/control) and the board members decided to submit letters to the State legislator in support of this position paper (scored, interaction/integration). The

position paper basically supported various methods to increase mental health funding in the state.

The Director informed the board about the new funding mechanism known as "block grants." He stressed that the State government under this legislation will play a major role in deciding upon appropriations to the various community mental health centers. He urged all board members to inform their legislators on the State level of the importance and need for continuation of community mental health centers (scored direction control).

The Director informed the group that a new program has been developed for families of clients in the partial hospitalization program, the after care program of the adult outpatient unit, and the inpatient unit. He stated that the goals of the program are informational, educational, and to enhance the support systems of the patients. The date, time, and location of the first meeting was announced and board members were invited to attend (scored, direction/control).

At the end of this fifth session of tabulating the consumer provider interaction score, the results for this session were:

interaction/integration - 1

direction/control - 3

First Session Prior to Training - February, 1982

One of the professional staff members of the Review Committee reported to the advisory board that the

service needs of the catchment area were discussed and how well these needs are met at the present time. Posters informing the public of the services of the Center will be set up at certain locations, especially in banks, where the services of the Center available to older people will be posted on the day the Social Security checks are received (scored, direction/control).

The Director informed the group that the Center was awarded a Grant to offer a Youth Leadership Conference. The goal of the conference will be to interest and train young people for participation in mental health advisory boards. The date, time, and location of the conference was announced and advisory board members were urged to invite any high school students they knew who might be interested in such a conference (scored, direction/control).

Some of the board members expressed concern for patients who are experiencing loss of SSI payments due to the new eligibility requirements on the Federal level. They felt these people are unable to help themselves in fighting these new rulings. The board suggested that a meeting be held with the Center's staff and other agencies involved to discuss what could be done to reverse this trend (scored, interaction/integration). The matter was referred back to the Review Committee. As this committee is provider controlled, this action was scored as direction/control.

At the end of this sixth session of tabulating the consumer/provider interaction score, the results for

this session were:

interaction/integration - 1

direction/control - 3

For the total six sessions of the experimental group the summative scores were:

interaction/integration - 9

direction/control - 2

Summary of Sessions

The major issues discussed in these six sessions were the availability of contacting a therapist after working hours, the problem with the drop in census and the pending "block grant" legislation. The issue of therapist availability was explained to the group and follow-up was made by the Director of the Mental Health Center.

Apparently, some of the lay members of the board did not understand why some therapists gave their home telephone numbers to patients and others didn't give their numbers.

The issue of decreasing patient census mentioned by the administration of the Center was discussed by the group. The consumer members felt there existed a need for an additional satellite clinic but did not relate to cost factors. The administration engaged in delaying tactics concerning the issue and eventually did not refer to it at all.

Board members were informed of the pending "block grant" legislation which seemed to demonstrate the Center's

apprehension concerning this change in funding procedures. Board members were asked to write letters to legislators to ensure mental health funding.

Experimental Group - Interaction/Control

Score Following Training

Background

The Center has proposed to remove psychiatric services at one of its outreach programs. These services consisted of providing outpatient treatment in the community and of making referrals to the community mental health center when a client needed services not offered by the outreach clinic. The rationale for this decision consisted of the low levels of service generated by this outreach program. The Center felt the unit was not cost effective.

First Session Following Training - November, 1982

Considerable discussion occurred around the diminution of psychiatric services at the outreach program of the Center. The Department of Psychiatry was viewed by the group as the responsible party for this decision. The Director of the Medical Center had endorsed this position. Several members of the advisory board stated they had received complaints from the community concerning this proposed diminution of services. The advisory board decided to take the following actions:

1. Submit a letter to the Director of the Center's Medical Hospital urging the continuation of psychiatric services

at the outreach program, urging the Center to allow the program more time in meeting its levels of services and requesting the Chairperson of the advisory board along with the Director of the Community Mental Health Center to meet with him (scored, interaction/integration). Copies of this letter will be sent to appropriate City officials.

The Director announced that the first citywide meeting of the City's Federation of Mental Health, Mental Retardation and Alcoholism Services will be held. The date, time, and location were given. This meeting is open to the public and all board members were urged to attend (scored, direction/control).

Prior to this meeting of the advisory board, the Executive Committee had discussed their concerns over the proposed integration of the community mental health center and the Department of Psychiatry. The board members proceeded to discuss the implications of any such merger. The group concluded that a letter be sent to the Director of the Center's Department of Psychiatry indicating the board's concerns about the plan's lack of including any mention of an advisory board and the plan's proposed cuts in outreach and liaison services (scored, interaction/integration). It was also agreed that the advisory board would request to meet with the Director of the Medical Center regarding this

proposed integration of program (scored,
interaction/integration).

The advisory board had heard that the Department of Psychiatry also plans to build an additional 21 bed inpatient psychiatry unit under the aegis of the Department of Psychiatry. The advisory board felt that this proposal should be discussed with the board prior to the Center's application for approval from the various funding sources. It was decided to submit a letter to the Director of Psychiatry to indicate the advisory board's concerns about this. It was further decided to submit a copy of this letter to the various funding sources (scored, interaction/integration).

At the end of this first session of tabulating the consumer/provider interaction score, the results for this session were:

interaction/integration: 4

direction/control: 1

Second Session Following Training - December 1982

It was announced that due to the intervention of the advisory board and letters from the community, the psychiatric services of the outreach program would not be reduced(scored, direction/control).

Board members also met with the Director of Psychiatry regarding the proposed integration of the Department of Psychiatry and the Community Mental Health Center. The Director indicated that no final determination

has been made on this matter. A follow-up meeting with the Director has been set. The chairperson of the advisory board will be present and report back to the group (scored, interaction/integration).

The issue of block grant funding arose during the meeting. Since the amount of funding which will be available for mental health programs is uncertain, the board decided to write to the State Senator who is the Chairperson of the Mental Health Committee, requesting to meet with him to discuss funding for the Center (scored, interaction/integration).

During the past month a programmatic audit of the Center was performed by the local governmental funding agency. The auditors indicated their concern that the community mental health center remain a separate administrative structure from the Department of Psychiatry. This group also met with representatives of the advisory board and were firm in their commitment to the continued need of the advisory board.

At the end of the second session of tabulating the consumer/provider interaction score, the results for this session were:

interaction/integration: 2

direction/control: 1

Third Session Following Training - January, 1983

The Director informed the group that the exit interview of

an independent programmatic audit would be held on a certain date. This statement was made in the context of his report on the programmatic audit. The chairperson requested that she and other interested board members be allowed to attend this exit audit (scored interaction/integration). (This information is from the observers own personal notes. It is not contained in the minutes of the meeting.) The Director agreed to their request (scored, direction/control).

It was announced that a meeting was held with the Director of the Medical Center. Present were the Director of the Community Mental Health Center and the Chairperson of the Advisory Board. A representative from the city funding agency also was present. It was agreed at the meeting that the CMHC would remain a distinct administrative entity. Within the context of this plan, there will be efforts to eliminate duplication such as, a centralized intake for Children's Services. It was stated that other eliminations of duplication will be reflected in supervisory positions (scored, direction/control).

At the end of the third session of tabulating the consumer/provider interaction score, the results for this session were:

interaction/integration: 1

direction/control: 2

Fourth Session Following Training - March, 1983

(The February meeting was cancelled due to

inclement weather.)

The Director reported on meetings which had taken place within the community mental health center. With the approaching end of the Federal funding cycle, there will be a gap of several hundred thousand dollars. Some positions will be kept vacant to fill this gap. A new program organizational table has been discussed to further cut costs. (This table of organization was distributed to the group.) The Director urged the board members to send letters to the State requesting that monies from the Block Grant be made available not only to community mental health centers still in this funding cycle but also to those centers who have graduated (scored, direction/control).

The Director reported that a rally is planned in the State Capitol to protest budget cuts for local assistance. All board members were encouraged to attend the rally (scored, direction/control).

One of the consumer members of the board raised the issue of the need for new membership. She presented a list of organizations which can be canvassed. She submitted her list to the Director's office (scored, interaction/integration).

The Director reported that additional staff had been hired for the outreach program. (This was in response to a board request and hence, scored direction/control).

The Director and the Chairperson reported on the independent exit audit. Some deficiencies were noted in the

medical reports and the psychosocial evaluations, otherwise, the review proved satisfactory. (Since the board's presence at the exit interview had been requested in the previous meeting, the administrative permission to attend was scored, direction/control.)

The Director announced that City officials would be conducting an audit of the Center. They will meet with Directors of the various components of the Center and review charts. The Chairperson requested that board members be allowed to be present at the exit interview as they were at the exit interview of the independent audit (scored, interaction/integration).

At the end of the fourth session of tabulating the consumer/provider interaction score, the results for this session were:

interaction/integration - 2

direction/control - 4

Fifth Session Following Training - April, 1983

Between the fourth and fifth sessions of the advisory board meetings, the Chairperson had contacted officials of the city funding source to send representatives to their advisory board meeting. The board wished to discuss proposed budget cuts. Two representatives from the city agreed to attend the meeting (scored interaction/integration).

At the meeting the board members questioned the

city representatives concerning this proposed reduction in program. The representatives indicated that their department does not have the responsibility for making the final decision in these matters. They suggested the board members contact the city commissioner of mental health services, local legislators, and the mental health representatives from the planning boards. After discussion on this topic, the board decided to send a letter to the local commissioner of mental health services requesting to meet with her and protesting the proposed cuts (scored interaction/integration). The board also decided to submit a similar letter to the local legislator to protest these proposed reductions in program (scored, interaction/integration).

The Director reported that he will be the keynote speaker at a conference on Alcoholism. It will be held at the Center. All board members were urged to attend.

Between this meeting and the previous one, the Director had informed the Executive Committee of the proposed budget cuts and requested their intervention with appropriate governmental officials (scored direction/control).

At the end of the fifth session of tabulating the consumer/provider interaction score, the results for this session were:

interaction/integration: 3

direction/control: 1

Sixth Session Following Training - May, 1983

The Nominating Committee presented a slate of officers to the advisory board. These nominations will be voted upon at the time of the next advisory board meeting. No further nominations were suggested by board members.

A board member again raised the issue of the need for additional consumer representatives at the advisory board meetings (scored interaction/integration). The Director of the C.M.H.C. noted that there is an upcoming mental health fair. A fact sheet will be distributed at this fair for people to sign who express an interest in advisory board membership (scored direction/control).

The Chairperson announced that follow-up letters will be sent to the local commissioner of mental health services concerning the proposed C.M.H.C. funding reductions (scored interaction/integration).

The Director of the Center presented a budget update to the board members. He noted that no official response has been received from the city concerning the Center's budget proposal. In his discussion with a federal government official concerning the proposed budget, that official made several recommendations to the Director. The official noted that the community advisory board needs to be shown on the Center's table of organization. He felt also that the program description needs to indicate a detailed conflict resolution procedure for those services which will have joint responsibilities to the Department of Psychiatry

and the Community Mental Health Center. The Director suggested that these issues be explored at the time of the next advisory board meeting (scored, direction/control).

At the end of the sixth session of tabulating the consumer/provider interaction score, the results for this session were:

interaction/integration: 2

direction/control: 2

For the total six sessions of the experimental group following training, the summative scores were:

interaction/integration - 14

direction/control - 11

Summary

Several potential crises occurred during this six month period. The administration of the Medical Center decided that one of the storefronts of the mental health center should be reduced or eliminated as it was not cost effective. Community opposition arose and the advisory board played a role in this issue.

The Center also presented tentative plans to integrate the Department of Psychiatry and the Mental Health Center, again, under the rationale of cost effectiveness. The advisory board became opposed to this idea as the proposed integration did not provide for an advisory board. They requested to meet with the Director of the Center which was approved. The Executive Committee met twice with him

and the advisory board sent letters to the Center's funding bodies opposed to this plan. Eventually, the Center withdrew its proposal.

Potential budget cuts were another major issue during this period. The Center solicited the support of the advisory board. The board was able to have two representatives from the funding body attend their meeting and the board sent letters to the city commissioner of mental health opposed to these reductions.

The board was involved in independent programmatic audits of the Center's program and attended the exit interviews with the administration of the facility.

The following interaction scores represent the findings from this analysis. Both the interaction/integration scores and the direction/control scores are summed. An interaction score is computed by dividing the total number of interaction/integration observations by the total number of direction/control observations.

	Interaction Score	Control Score
Before Training	9	22
After Training	14	11

The interaction score prior to training is .41 and the interaction score following training is 1.27. It is to be noted that prior to training most topic areas were initiated by the administrative representatives to the

advisory board (71%), computed by dividing the control score by the total score $22 \div 31$). Following training, this percentage of topic areas initiated by the administrative representatives to the advisory board meeting dropped to (44%), computed by $11 \div 25$). Those topics initiated by the consumer members of the board increased from 29% prior to training ($9 \div 31$) to 56% following the training ($14 \div 25$). The interaction score, a dichotomous measure of sociometry, increased as a result of the training. The figures below summarizes these results.

	Consumer Initiated Topics	Provider Initiated Topics
Before Training	29%	71%
After Training	56%	44%

These findings would support the first propositional statement of this project and collaborate the author's personal perceptions of the board meetings.

The Comparison Group

The same consumer/provider interaction scores were obtained for the comparison group using the same time frame as was used for the experimental group. Following presentation of the results, a comparison will be performed between the experimental and comparison groups.

Comparison Group - Interaction/control

Scores Prior to Training

Sixth Session Prior to Training - September, 1981

The Medical Center had begun constructing an

inpatient psychiatric unit which would be an additional unit to the existing psychiatric unit of the Community Mental Health Center. What would be the relationship between the two centers, their respective catchment areas, and lines of authority were issues raised by the board members. After considerable discussion, the board decided to request a written report from the Medical Center addressing these issues (scored interaction/integration). The administrative members of the Center present indicated that a meeting would be set up to discuss the new patient unit (scored direction/control).

Prior to this meeting, one of the patients at the community mental health center died of an overdose. A report was presented to the board members by the administration of the Center (scored direction/control). The board members were accepting of this report but wanted to know the number of past suicides at the Center (scored interaction/integration). The Director of the Center stated that he would have his Medical Director attend the advisory board meeting to discuss the issue of suicides at the Center and suicide prevention (scored direction/control).

The Director reported a pending site visit by city officials and urged all board members to attend a session with these officials which will be arranged by the Center (scored direction/control).

An issue arose concerning the referral of a patient to a specific unit of the Center rather than the

admissions office. The Director informed the board that this procedure was incorrect. All potential patients should be referred to the admissions office of the Center (scored direction/control).

One of the board members indicated the need of expanding the geriatric services to senior centers contained within the center's catchment area (scored interaction/integration). There was no immediate response from the administrator present at the meeting.

At the end of this first session of tabulating the consumer/provider interaction score the results were:

integration/integration - 3

direction/control - 5

Fifth Session - October, 1981

It was announced that the board had interviewed five people for a position at the mental health center. In the discussion, the board indicated that they disagreed with the administration's choice of candidate and urged the Center not to hire this person (scored interaction/integration). After considerable discussion, the administration agreed with the board's choice of candidate (scored direction/control).

A report was given by the administration concerning the Medical Center's new inpatient unit. The linkages with the Center were discussed (Since this was in response to last sessions agreement by the Center to present a report, no score was tabulated again.)

A report was given by the administrator on the pending "block grant" legislation and its impact on the Center (scored direction/control). Discussion ensued on the topic but no specific requests or recommendations were made.

At the end of this second session of tabulating the consumer/provider interaction score, the results were:

interaction/integration - 1

direction/control -2

Fourth Session -November 1981

It was announced that the Director of the Center would be retiring shortly. Discussion ensued on this topic and the procedure which will be followed to hire a new director. The board requested a separate meeting to be held with the administration of the Center around this issue (scored, interaction/integration). The administration agreed with this request and set up a time and place for this meeting (scored direction/control). This was the only issue discussed at this meeting.

At the end of this third session of tabulating the consumer/provider interaction score, the results were:

interaction/integration - 1

direction/control - 1

Third Session - December, 1981

A request was made by the board members for the Center to appoint a part time social worker to the board. This person would act as liaison between the board and the

Center in between the monthly meetings of the board (scored interaction/ integration). There was no immediate response from the administration of the Center other than the issue would be discussed at the Center.

A further report was given by the administration of the Center on the pending "block grant" legislation and its potential impact on the mental health center (score, direction/control).

At the end of this fourth session of tabulating the consumer/provider interaction score the results were:

interaction/integration - 1

direction/control - 1

Second Session - January, 1982

The administration announced that the Center will provide "orientation meetings" with new board members (scored direction/control). (Apparently, this was in partial response to the Board's request for the appointment of a part time social worker to the board.)

The administration informed the board of pending contract negotiations with the city department of mental health. The need for the board's support in these negotiations was discussed with the board members (scored direction/control).

The board was informed by the administration of the Center that a council of community advisory board's is in the process of formation. It would include

representatives from all the advisory boards of the city's community mental health centers. The role of the board with this group will be explicated when further information is available(scored direction/control).

At the end of this fifth session of tabulating the consumer/provider interaction score, the results were:

interaction/integration - 0

direction/control - 3

First Session - February, 1982

The group was informed by the chairperson that three people had been interviewed for the administrator's position by the executive committee. Discussion followed concerning these candidates. The group decided that further candidates need to be considered (scored, interaction/integration).

The board members were informed by the chairperson that five of the day hospital patients had requested the help of the advisory board. All five of them had been informed by the federal government that they were no longer eligible for Social Security Increments (SSI). After discussion of this issue the group decided to form a committee to investigate this matter and recommend action by the advisory board (scored, interaction/integration). The administrators present at this meeting voiced their concern over these recent cutbacks in Social Security benefits and its impact on the Center. They recommended political action by the

board members such as a letter writing campaign to State and local legislators (scored direction/control).

The rest of the session was spent on whether to expel a member of the advisory board. This person's wife is an employee at the Center. Following discussion of the issue, the board voted not to expel the board member;

Following this session of tabulating the consumer/provider interaction score, the results were:

interaction/integration - 2

direction/control - 1

The summative total score for these six sessions of the comparison groups was:

interaction/integration-8

direction/control - 13

The Comparison Group - Provider/Consumer
Interaction Score (Following the Training
of the Experimental Group)

For a six month period following the training of the experimental group, the minutes of the comparison group were examined to produce a consumer/provider interaction score. The same time sequence was used for recording these minutes of the comparison group as was used to record the minutes of the experimental group. The trainer was present at these six sessions of the comparison group. No difference was noted between the recorded minutes of the meeting and the observer's own minutes.

First Session - November, 1981

Several board members brought up the issue of the functions of the weekly Director's meeting. The administrator present described this weekly meeting as a review of the various Department's activities of the week and to present any policy changes to the group. The advisory board members requested that their Executive Committee be allowed to attend these meetings (scored interaction/integration). The administrator present indicated he would have to discuss this issue with the Director of the Center.

The administrator present at the meeting informed the group of the various problems encountered in the construction of the Medical Center's new inpatient psychiatric unit. This information was provided to inform the group of progress in the construction of the unit and how it affects the mental health center (scored, direction/control). A discussion ensued on this topic which continued for the remainder of the meeting.

At the end of tabulating this first session of the consumer/provider interaction score, the results are:

interaction/integration - 1

direction/control - 1

Second Session - December 1982

The new inpatient unit was discussed again by the group along with rumors of additional expansion plans of the Medical Center. After discussion, the group decided to send

a letter to the administration of the Medical Center seeking the "advice and consent" of the advisory board in all phases of any planned expansion of the Medical Center (scored interaction/integration). The administrative members of the Center played a passive role during this discussion.

The advisory board members were informed by one of the administrators that the Director of the Community Mental Health Center had decided to disallow the board's request to attend the weekly Director's meeting (scored, direction/control). This was in response to a request from the board during last month's advisory board meeting. Some discussion ensued on this matter but no formal response was made by the board.

At the end of this second session of tabulating the consumer/provider interaction score, the results were:

interaction/integration - 1

direction/control - 1

Third Session - January, 1983

The issue of the appointment of a new Director of the Community Mental Health Center arose. After discussion, the board requested to become part of the "search team" that the Medical Center established (scored, interaction/integration). The administrator present at the meeting stated he would take their request to the Medical Center and indicated the Center's support for their request (scored, direction/control). (This request was approved by

the Medical Center.)

The issue of job opportunities at the Center was discussed. At the present time, different job vacancies are posted on the separate bulletin boards of each Department. The board members felt that all job openings at the Center should be recorded on the Center's "hotline", and made this request of the administration (scored interaction/integration). No immediate response was made by the administration rather than the need to take the matter back to the Director.

Some planned cutbacks in caseload in the adult inpatient psychiatric unit were mentioned in the meeting. This is due to the current construction of the new inpatient psychiatric unit on the floor above the Center's inpatient unit. Several board members voiced their concern over these cutbacks faced with the community's need for psychiatric beds. The board decided to request a meeting with the Director of the Adult Inpatient Unit to discuss these proposed cutbacks and the permanency of them (scored interaction/integration).

At the end of this third session of tabulating the consumer/provider interaction score, the results were:

interaction/integration - 3

direction/control - 1

Fourth Session - February, 1983

The issue was raised by the chairperson that the position of Director of the Consultation and Education

programs at the Center has been vacant for two to three months. Since this position directly affects the operations of the various community programs of the Center, the board members requested that this position be filled as soon as possible (scored, interaction/integration). The administrator present at the meeting indicated that some candidates remain to be interviewed but an appointment should be occurring soon (scored, direction/control).

The board members also voiced their concern for the continued need to expand outreach programs of the Center. Various existing outreach programs were mentioned which the board members felt needed expansion (scored interaction/integration). No immediate response was given by the administrator present at the meeting.

The administrator gave a report on the process of construction for the new inpatient unit and invited discussion from the advisory board members (scored direction/control).

At the end of this fourth session of tabulating the consumer/provider interaction score, the results were:

interaction/integration - 2

direction/control - 2

Fifth Session - March, 1983

It was announced that two candidates for the position of Director of the Consultation and Education Unit would be interviewed this week.

A meeting was held between representatives of the

community advisory board and the local police concerning the issue of vandalism in the community.

The board members discussed again the issue of selecting the new Director of the Community Mental Health Center. The board requested a statement of the hiring criteria for the position (scored interaction/integration). The administrator at the meeting announced that select board members would be invited to attend the meetings of the search committee (scored direction/control).

The board members were informed of the results of an internal study of length of stay in the Emergency Room. Questions concerning this study were solicited from the advisory board members (scored direction/control).

The administrator informed the group of possible reduction in State or local funding of the Center's contract. All board members were urged to become involved in fighting these reductions (scored, direction/control).

At the end of this fifth session of tabulating the consumer/provider interaction score, the results were:

interaction/integration - 1

direction/control - 3

Sixth Session - April, 1982

The administrator present at the meeting informed the group of the current blood drive at the medical center. He urged the board members to inform community groups about the need for blood donations (scored, direction/control).

The group decided to refer the matter to the board's executive committee for a plan of action.

The administrator present at the meeting also reported low census in the children's outpatient clinic. He urged the board members to elicit referrals from community groups and from local religious leaders (scored, direction/control).

The main discussion of the meeting consisted of nomination of officers for the coming year. It was agreed that the Executive Committee would present a list of potential officers at the next meeting.

At the end of this sixth session of tabulating the consumer/provider interaction score, the results were:

interaction/integration - 0

direction/control - 2

For the total six sessions of the comparison group (following the training of the experimental group) the summative consumer/provider interaction scores were:

interaction/integration - 8

direction/control - 10

The following interaction scores show the difference between the comparison group for the six sessions prior to training of the experimental group and for the six sessions following the training of the experimental group.

	Comparison Group Interaction score	Control Score
Before Training	8	11
After Training	8	10

An interaction score is computed from this data by dividing the total number of interaction/integration observations by the total number of direction/control observations. The interaction score prior to training is .73 and the interaction score following training is .80.

This comparison shows that there occurred virtually no change in the interaction scores of the comparison group.

The following table displays the consumer provider interaction scores of the experimental group and the comparison group before and after the training period.

Table 4

	<u>Experimental Group</u>		<u>Comparison Group</u>	
	Interaction Score	Control Score	Interaction Score	Control Score
Before				
Training	9	22	8	11
After				
Training	14	11	8	10

<u>Interaction Score</u>	<u>Interaction Score</u>
Before Training - .41	Before Training - .73
After Training - 1.27	After Training - .80

This table reveals that some increase occurred in the interaction scores of the experimental group following training while the interaction scores of the comparison group increased less. This analysis provides some

evidence to the first propositional statement of this project, namely that statistically higher levels of consumer participation will occur as a result of a training program which clarifies their role and activities and educates them in the mental health service delivery system.

Content Analysis of the Minutes
Relevant to the First Propositional Statement

As indicated previously, besides analyzing a change in the number of interactions between the board and administration of the Center as contained in the development of the interaction scores, the minutes of the board's meetings were subjected to a content analysis to determine changes in the types of activities of the board to test the first propositional statement of this project.

This involved the schema developed by Metsch and Veney which tests whether an increase or decrease in the types of activities occurred as a result of the training program. This schema differentiates among eight, mutually exclusive and exhaustive categories which describe the board's activities and the administration's activities. Unlike the consumer/provider interaction score which scored interaction in the advisory board meeting by which group initiated topics of discussion, the activities are scored based upon consumer requests or recommendations to the administration and the administrative response to these requests or recommendations.

The eight categories are:

1. The board requests a change in hospital policy requiring an allocation of services (e.g. initiate a new program, hire new personnel, improve an existing service.)
2. The board requests information within the organization of the program, (i.e., provide information, manpower or financial data); investigate complaints; provide workload.
3. The board requests information not within the organization (e.g., provide information on a community agency's program)
4. The board requests support for an external program (e.g., provide medical support for a local drug program)
5. The board requests the Center to provide tangible support to the board (e.g., pay expenses so the members can attend meetings)
6. The board requests support service on behalf of the board (e.g., write a letter to a legislator, provide stationary for the board, prepare an informational brochure).
7. The board requests a change that does not require an allocation of resources (e.g., install a complaint box in the clinic, install bilingual signs in the emergency room)
8. The board requests the Center to conduct a feasibility study on a committee proposal that involves a potential allocation of resources (e.g., study the feasibility of a mobile clinic)

Content Analysis of the Minutes
as It Relates to the First
Propositional Statement

For a six month period, the minutes of the advisory board which received the training were coded to produce a consumer input score and an administrative action score as delineated in the previous chapter. The results are as follows:

Sixth Session Prior to Training - September, 1981

Recommendation/Request:	Category	Consumer Input Score	Adminis- trative Action Score
1. need for another facility	1	8.81	No Response
2. how to reach therapists after hours.	2	6.70	5.91

The instructions from the Metsch and Veney study were not clear on the issue of what constitutes "no response" from the administration. Although a response could be given to a consumer request, it could be a meaningless response or even a canard. For the purposes of this study, the administrative response was coded "no response" if there did not occur an attempt on the part of the administration to implement or to take concrete action to explore the possibility of implementing the consumer request or recommendation - as long as it was a feasible request.

For instance, in this session the issue of a drop in out patient census arose. Consumer members of the advisory board noted the problem of double fare to reach the center and the general inconvenience of its location for the community. They made the recommendation that another facility more centrally located which would make the services of the center more accessible to its catchment area population was needed. The administration's response was that the Director of Social Services would be appointed to

check out space in the community for such a facility. In subsequent sessions the matter was once mentioned, namely, that space for such a clinic was under investigation. In subsequent meetings, a crisis also arose and the matter was not mentioned again. Hence, this was scored as "no response" since no positive action was taken and it appeared that the administration dealt with the issue by a series of delaying tactics. On the other hand, the administration did actively pursue the issue of patient complaints concerning contacting their therapist after hours if an emergency arose. For this reason, an administrative action score was given to the consumer's recommendation.

Fifth Session Prior to Training - October, 1981

Recommendation/Request:	Category	Consumer Input Score	Adminis- trative Action Score
1. patient charts should be made available to emergency room staff after hours.	7	7.18	No response
2. ways to publicize the services of the center.	7	7.18	No response

Concerning this request, the administration explained to the advisory board members that patient chart's could not be kept in the emergency room since this would constitute a breach of confidentiality. The administration did agree to explore the possibility of placing a central registry of patients in treatment but, again, the matter was dropped.

During the next two sessions of the board, (the fourth session and the third session prior to the training sessions) no specific consumer requests or recommendation occurred. This did not occur in the Metsch and Veney study which may reflect the fact that their study involved a board in the formative stages of development where roles and role relationships are undergoing formation. This advisory board has been meeting for years where those relationships are less transient and where issues already have been explored and tested.

Second Session Prior to Training - January, 1982

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. Need to secure housing for discharged psychiatric patients in the catchment area. A housing project in the area will not admit them due to the large number of homes in the project for the retarded.	4	7.55	No response

The administration of the community mental health center responded to this issue by indicating a report would be presented at next month's meeting. Only a cursory mention of the issue occurred at the next meeting and the issue was dropped. Hence, a "no response" score in the administrative action score was coded.

First Session Prior to Training - February, 1982

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. members expressed concern over SSI recipients who have been terminated and require assistance to care for themselves. Requested CMHC to call meeting of other agencies involved to ensure linkages of services.	4	7.55	No response

Again, the minutes do not indicate any response from the administrative representatives at the meeting and subsequent minutes and the trainer's own notes indicate no reference to the issue.

Following completion of the training sessions, the minutes of the advisory board meetings were coded to produce a consumer input score and an administrative action score. In addition, these scores were tabulated upon the trainer's personal notes of the sessions in addition to the recorded minutes. The results are as follows:

First Session Following Completion of
Training - November, 1982

Recommendation/Request	Category	Consumer Input Score	Administrative Action Score
1. Hospital plans a cutback in an outreach program.. Board sends letter of protest to Director of hospital and requests a meeting with the Director.	1	8.81	8.76
2. Hospital plans integration of CMHC with Hospital's Department of Psychiatry. No mention is made of a consumer advisory board in the integration. Board request meeting with Director and sends letter of concern.	7	7.18	5.79
3. Board opposes cutbacks in outreach programs. Sends letter to city officials and Director of Hospital requesting meeting.	1	8.81	8.76
4. Board wishes to comment on any integration of services plan.	2	66.70	5.91
5. Hospital plans to build a 21 bed psychiatric inpatient unit. Board sends a letter to the Director indicating this proposal should be discussed with the advisory board.			

For reasons that were not explained in the advisory board meeting, the medical hospital prepared a draft calling for the integration of the CMHC with the Department of Psychiatry. Outreach programs would be reduced as a cost saving measure and some CMHC services would be integrated with services of the medical hospital, ostensibly, to reduce duplication and costs. In addition, the proposal did not mention the role of the consumer advisory board.

This constituted a crisis for the board. Their requests for meetings with city officials and with the Director of the Center's Hospital were granted. As a result of a bargaining process, the hospital withdrew its proposal for integration of services. The board and the administration of the community mental health center were able to elicit public support to maintain the outreach programs, the recognition of the consumer advisory board to the center, and the withdrawal of the hospital's proposal for the integration of the two services.

There were no specific consumer requests or recommendations during the second session of the advisory board meeting following training. Most of the session involved a report of the issues and meetings held regarding the proposed integration plan.

Third Session Following Completion
of Training - January, 1983

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. Board requests to attend exit interview of an independent program evaluation of the CMHC in conjunction with the State office of Mental Hygiene.	3	7.38	5.73

In conjunction with the State Office of Mental Hygiene, an independent group which monitors the quality of care in hospitals had performed a programmatic audit of the facility. The board members requested to be present at the

exit interview to receive information concerning their findings and for the board's input into their comments. The administration of the Center complied with their request. This programmatic audit is a bi-annual event.

Fourth Session Following Completion
of Training - March, 1983

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. Board request to attend exit interview of City audit.	3	7.38	5.73

The following month, the local City government which, in part, funds the community mental health center conducted its own programmatic audit of the facility. Again, the board requested its members to be present at the exit interview which the administration of the Center agreed to and supported.

Fifth Session Following Completion of Training
April, 1983

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. The Center had received information from the City that there would be some budget cuts this fiscal year. The board requested to meet with authorized representatives of this body	3	7.38	5.73

The Center had been informed that there would be some cuts in its budget this fiscal year. This information was given to the community mental health center in writing by the funding agency which administers this contract. Upon receiving this information, the board requested the administration of the Center to invite representatives of this agency to meet with the board. The administration agreed to do so.

Two representatives from the funding agency met with the board members who raised the issue of the reasons for the reduction in funding and what steps could be taken to restore the cuts. The representatives noted that these cuts are to be made in all units of the program and result from decreased funding from their agency which emanated from the mayor's office. The representatives recommended that the advisory board contact and meet with the local commissioner for mental health services and with the mayor's representative in their section of the city.

At the sixth session following completion of the training, there was no specific consumer requests or recommendations. Discussion continued concerning the proposed cuts in program. The advisory board had sent letters to the local commissioner of mental health services and the mayor's representative for their area.

No response had been received from either party. The advisory board decided to sent follow-up letters to these people.

Mean and Standard Deviation Prior to Training
and Following Training

Contructing a table to reflect the mean and the standard deviation for the consumer input score and the administrative action score produces the following results:

<u>Table 5</u>		
	<u>Consumer Input Score</u>	<u>Administrative Action Score</u>
Before Training	M= 7.56	5.91
	S.D. = .782	
After Training	M= 7.66	M = 6.63
	S.D. = .819	S.D. = 1.456

The table reveals several significant changes. Prior to the training there occurred only one administrative response to five consumer recommendations/requests. The mean of the consumer input scores is 7.56 which would fall into category IV - "the board requests support for an external program." This represents one rank above an internal focus on the part of the board members. It does not relate to general policy issues which would require an allocation but does denote an outward focus. No mean or standard deviation is possible for the administrative action scores prior to training since there was only one administrative response to the consumer

recommendations/requests.

Following training, the major change is the administrative action score. Every consumer recommendation/request was responded to by the administration of the Center which is an increase from a 20% response to a 100% response. Both the mean of the consumer input scores (7.66) and the mean of the administrative action scores (6.63) fall into Category VIII, "the board asks the hospital to conduct a feasibility study on a board proposal that involves a potential allocation of resources." This focus may represent more realistic efforts on the part of the board in dealing with the administration of the Center based upon the training program.

No correlation coefficient could be constructed for the consumer input score acting as the x variable and the administrative action score acting as the y variable since there occurred only one administrative action score during this period. Following the training the coefficient correlation for the two sets of values came to .942 a positive correlation between the two scores and a strong correlation as the figures nears a positive one. This provides statistical significance for the variables within the .01 range.

Content Analysis of the Comparison Group

Prior to Training of the Experimental Group

For a six month period prior to the training of the experimental group, the minutes of the comparison group were subjected to a content analysis. The exact same time sequence was involved. Like the experimental group, only the minutes of the comparison group were analyzed since the trainer was not present at these meetings of the comparison group. The results are as follows:

Sixth Session Prior to the Training

Period: September, 1981

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. The board requests the Center to provide a report detailing their plans for an additional inpatient unit	2	6.70	5.91
2. The board requests the Center to expand geriatric services	1	8.81	No Response

Fifth Session Prior to the Training

Period: October, 1981

Recommendation/Request	Consumer Input Score	Adminis- trative Action Score
1. The board interviewed five people for a position at the Center. The board disagreed with the Center's choice and requests the Center not to hire the person.		

Fourth Session Prior to the Training PeriodNovember, 1981

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. The board request a separate meeting with the administration of the Center concerning the Appointment of a new Director to the Center.	2	6.70	5.91

Third Session Prior to the Training Period:December, 1981

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. Board requests the appointment of a part-time social worker to the board.	6	5.98	No response

During the next sessions, there were no specific requests or recommendations from other board members. Following completion of the training sessions with the experimental group, the minutes of the comparison group were coded to produce a consumer input score and an administrative action score for a six month period. Again, the same time sequence was used between the group and the comparison group. As stated, there was no difference between the recorded minutes of the meetings and the trainer's own notes.

First Session Following the

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. The board requests to attend the Director's weekly meeting with the administrators of the Center	2	6.70	No response

Second Session Following the TrainingPeriod: December, 1982

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. The board requests the Medical Center to seek the "advice and consent" of the advisory board in its planned expansion programs.	2	6.70	No response

Third Session Following the TrainingPeriod: January, 1983

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. Board requests to become part of the search committee for new Director of the Center.	6	6.70	5.91
2. Board requests that all job openings at the Center be recorded on the Center's "hotline".	6	6.70	No response
3. Board requests to meet with the inpatient unit director over their concerns on cutback in caseload.	6	6.70	5.91

Fourth Session Following the TrainingPeriod: February, 1983

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. The board requests "speedy" appointment of a new Consultation and Education Director	2	6.70	5.91
2. Board requests an expansion of out-reach services.	1	8.81	No response

Fifth Session Following the TrainingPeriod: March, 1983

Recommendation/Request	Category	Consumer Input Score	Adminis- trative Action Score
1. Board requests Center to provide the hiring criteria for the new director of the Center.	2	6.70	5.91

There were no specific request or recommendations from the board members during the sixth session following completion of the training period.

Mean and Standard Deviation Prior
To Training and Following the Training

Constructing a table to reflect the mean and standard deviation for the consumer input score and the administrative action score produces the following results:

Table 6

Consumer Input Score		Administrative Action Score
Before	M = 6.98	
Training	S.D. 1.07	Mode = 5.91
After	M = 6.99	
Training	S.D. = .75	Mode = 5.91

This table reveals little difference before and after the training period. The change in the mean score from 6.98 to 6.96 is deemed to be statistically insignificant. Only the mode score could be used in coding the administrative action score since all four scores were the same. No change occurred prior to and following the training. The mode score would fall into category II, rank

5 for the administration which reads, "the board requests information within the organization." The consumer mean score prior and following the training period would fall into the same category. This would seem to indicate that the consumers on the board and the administration of the Center have worked out over a period of time a process of mutual exchange which involves seeking and providing internal information concerning the Center. It does not relate to general policy issues which would require an allocation of resources or to an outward focus on the part of the board.

Out of five consumer requests prior to the training of the experimental group, two requests received no response from the administration of the comparison group (40%). Following the training period, four out of eight requests were coded "no response" on the part of the administration of the comparison group (50%). Five of the eight "no response" involved a category other than category II which would seem to indicate that the administration mainly responds to requests for internal information.

Table VII compares the mean and standard deviation of the consumer input scores and the administrative action scores of the experimental group and the comparison group.

Table 7

		Consumer Input Score	
		Experimental Group	Comparison Group
Before Training	M = 7.56 S.D. = .782	M = 6.98 S.D. = 1.97	
After Training	M = 7.66 S.D. = .819	M = 6.96 S.D. = .75	
		Administrative Action Score	
Before Training	Mode 5.91	Mode 5.91	
After Training	M = 6.63 S.D. = 1.46 (5.73 is the mode)	Mode 5.91	

This comparison shows that following the training period, the consumer input score of the experimental group increased by a mean score of .10 while the mean score of the comparison group dropped by .02 (which is not considered to be statistically significant). The administrative response between the two groups before and following training reveals little difference between the two groups. The mode score of the experimental group decreased by .18 and the mode score of the comparison group remained the same at 5.91.

Using the consumer input score as the x variable and the administrative action score as the y variable, prior to training the correlation coefficient between the two groups was .356, a positive correlation between the two scores. Using a "t" test table from the formula $t_{test} = \left(\frac{t^2}{t^2 + df} \right)^{\frac{1}{2}}$, this .356 correlation coefficient proves to be less than

80% significant. Following the training period, the correlation coefficient between the two variables is .298 which also is less than 80% significant. Hence, no inferences can be made between the scores in terms of their correlation coefficients.

Findings Relevant to the Second

Propositional Statement

The second proposition of this study states, "if the advisory board of a mental health center receives a training program which clarifies their role and activities and educates them in the mental health delivery system, then substantive changes will occur in the relationship between the advisory board and the administration of the Center." The proposition contains two main variables. The training program is the independent variable of this proposition. It was operationalized to mean the contents of the training sessions. The major dependent variable is "substantive changes in the relationship between the advisory board and the administration of the Center." It was operationalized to mean all non procedural changes in the relationship between the advisory board and the administration of the Center as measured by a content analysis of the minutes. Measurement of this dependent variable will also be analyzed by a descriptive analysis from personal interviews with the participants, the administration, and outside observers of the group. It will also be analyzed by reviewing the results of the post questionnaire.

For the purposes of this study the eight mutually exclusive categories were broken down to relate to procedural changes and substantive changes in the form of the consumer input scores. This was achieved by placing the consumer categories I and VIII, which relate to changes in the health care delivery system, and categories III and IV, which represent outward focus on the part of the board, into the category of "substantive changes." Categories VII and II which relate to an internal hospital focus and categories V and VI which relate to board operations in particular and only peripherally to the objectives of promoting mental health, were collapsed into the category, "procedural changes." The table below indicates the results of this analysis.

Table 8

Consumer Input Score - Experimental Group

	Procedural Changes	Substantive Changes
Before Training	2	3
After Training	2	5

There occurred no change in the number of procedural changes while there was a 40% increase in the number of substantive requests. While the number of requests is small, it is felt that the change represents some changes in the interaction between the consumer advisory board and the administration of the Center. It is to be noted that all five of these substantive requests following completion of the training were responded to by the

administration of the Center while the three substantive requests prior to training were rated "no response."

Using this same data analysis with the comparison group produces the following table.

Table 9

<u>Consumer Input Score - Comparison Group</u>		
	Procedural Changes	Substantive Changes
Before Training	4	1
After Training	7	1

There occurred no change in the number of substantive changes before or after the training sessions. Both substantive requests were rated "no response" from the administration. Of the procedural requests, three of the four prior to training were responded to and three of the seven following training were responded to. From this analysis, it appears that the comparison group had low input into the decision making of the Center's administration.

Results of the Post Questionnaire

Although the post questionnaire was distributed to all who attended at least one of the six training sessions, a total of 17 people, eleven questionnaires were received from the group in spite of recurrent attempts to secure them. Only one person attended all six sessions. That person's statements will be ranked first in the analysis of the data.

Each session was graded from "poor" to "average" to "above average" to "excellent" with space provided for "other comments" (see Appendix C).

The person who attended all six sessions gave the following ratings to each session:

<u>Session</u>	<u>Rating</u>	<u>Comments</u>
Session I	Above average	"the information and knowledge was shared in a clear, specific fashion."
Session II	Excellent	
Session III	Above average	
Session IV	Excellent	
Session V	Excellent	
Session VI	Above average	

The ratings presented below represent the ratings given in the post questionnaire by the ten other respondents.

<u>Session</u>	<u>Rating</u>	<u>Number</u>	<u>Mode</u>
I	average	4	Excellent
	excellent	6	
II	average	2	Above average
	above average	5	
	excellent	3	
III	average	3	Above average
	above average	4	
	excellent	3	
IV	above average	5	Excellent
	excellent	5	
V	above average	5	Excellent
	excellent	5	
VI	above average	5	Above average
	excellent	5	

The range of ratings varied from "average" to "excellent." Two other respondents commented on one of the sessions. One respondent indicated Session II was "most helpful " and another respondent indicated Session II as "input was minimal. Training would have to be more detailed and much longer time allotted."

The second question contained in the post questionnaire asked which session(s) proved most helpful and why.

Five people commented to the question. One stated, "none more than others as each was very informative." Another person responded, "Program Evaluation. The instructor mentioned areas of evaluation which were especially the domain of the advisory board (e.g. patient rights)." Another stated, "all sessions were helpful". Another stated, "all". Another stated, "the session that dealt with budgetary process - because explained the dynamics of how monies are used."

The third question contained in the post questionnaire asked which session(s) proved most helpful in understanding your role, functions and responsibilities as a board member. Three people responded to this question. One person stated, "all sessions." One person stated, "none more than others as each was very informative." Another person stated, "Program Evaluation. The instructor mentioned areas of evaluation which were especially the domain of the advisory board."

The fourth question asked which session(s) proved most helpful in understanding the mental health delivery system. Three people responded to this question. One stated, "Session IV (credentialing, certification and licensure) as it explained procedures otherwise unknown to me." Another person responded, "all . They made me feel very inadequate in dealing with matters of importance." Another person responded, "understanding my role."

The fifth question related to their ideas as to improve this type of training. Four people responded to this question. One stated, "the use of visual aids and films would be helpful." Another person stated, "same type of training ." Another respondent indicated, "intensive training in all areas." The fourth person stated, "some pre printed outlines prior to discussion."

The sixth question and the final one was reserved for "other comments". Two people submitted comments. The first person stated, "In general, I found all of the training sessions very helpful and valuable as they provided information and understanding of the mental health delivery system(s), and what my role, tasks, functions are and can be. I am grateful for the opportunity for such good [sic] learning experience.

The second person stated, "I feel the advisory board needs to know that this involvement is meaningful and not just be used to impress State, City or Federal [sic] for funding purposes. The trainer did his best to give us as

much valuable information as possible. I do know more, than I did before."

In general, the responses indicated a positive experience for the advisory board members. They felt that their knowledge base had increased and better understood their role as an advisory board member to a community mental health center. Some comments indicated the need for more detailed training in the areas covered in the six sessions. While ideally this is desirable, there do exist limitations of time in conducting the training sessions and a balance has to be reached. The use of visual aids is seen as a constructive idea.

In general, the results of the post questionnaire support the second propositional statement of this project, namely that substantive changes will occur in the relationship between the advisory board and the administration of the mental health center as a result of the training program. This conclusion was supported also by the analysis of the changes in the group discussions from procedural matters to substantive matters as a result of the training sessions.

In the next chapter, the author will discuss conclusions which can be drawn from this project and how this material can be used in future training of advisory boards to community mental health centers.

FOOTNOTES

1. Jonathan M. Metsch and James E. Veney, "Measuring the Outcome of Consumer Participation", Journal of Health and Social Behavior, 3 (December, 1973):368.
2. Ibid., p. 369.
3. Ibid., p. 371.
4. Ibid., pp. 368-374.

CHAPTER VI

CONCLUSION

In this chapter, the overall project will be reviewed. This will include concepts relating to citizen participation and the limitations of citizen participation, characteristics of the program setting, the major findings of the research project and the conclusions and implications of the project. Finally, the major limitations of training consumer advisory boards to mental health centers will be stated as learned from this project and recommendations will be made to improve consumer participation to community mental health centers.

Concepts Relevant to and Limitations of Consumer Participation

Based upon classical democratic theory, this project assumed that citizens should participate in those institutions, processes, and forces affecting their lives and the lives of other people in their community. Based upon the writings of Rousseau and Voltaire, the State is perceived as created by man to served its citizens and to ensure individual rights. This is to be achieved by a system of participatory democracy. In modern times, citizen participation generally has come to mean some type of

structured interaction between some local citizen group and a branch of government operating a specific program.

The contemporary thrust for citizen participation in the government's programs, especially the social programs, occurred under the Johnson Administration. The legislation creating many of these programs mandated various types of citizen participation.

In the mental health field, two major means of implementing consumer participation arose:

1. Representation on boards and advisory groups of mental health services
2. The use of indigeneous workers within the mental health system

This study related to the former, citizen participation on advisory boards of mental health centers, in particular, a community mental health center. The level of participation and the meaningfulness of it was examined in the research section of this study. Since this study took place at a community mental health center, the ideology of this movement and its historical development are examined. Growing out of concepts from the field of Social Psychiatry, the community mental health movement implemented the concept of "community care" which was a reaction against existent State facilities with their focus upon institutional care. "Community care" referred to providing total mental health care" to a designated community which became known as the "catchment area" of the community mental

health center. With its program of "community care" it focused on comprehensive mental health services, continuity of service, preventive services, indirect services, use of new sources of workers (the indigenous population), attempts to identify sources of stress within the community and provision of total mental health care to the residents of the community.

Several problems arose in implementing consumer participation as a result of the community mental health legislation.

The work "community" is difficult to define. Sociologists from the time of the modern day father of Sociology, Comte, have struggled with the term. For the purposes of this study, Tönnies typology was employed where he divided the term into two general types of communities, his gemeinschaft and gesellschaft classifications.

A gemeinschaft community can be likened to an extended family. An implicit bond relates person to person in such a community. This type of "community" is held together by a set of common rules, affection, respect, mutual dependence, and a sense of status hierarchy, usually based upon age. Its societal institutions reflect the values and customs of its citizenry. Formal values of relationship are minimal as the roles of the members of the community are set by the tradition and cultural expectations of the group.

Today, this type of community is rare in the United

States. Where it is still present, it is maintained by a radical provincialism. They resist acculturation. The Amish settlements of Pennsylvania are an example.

Due largely to the urbanization of America, today's dominant type of community is Tönnies second major classification of the word, the gesellschaft community. In this type of community, relations between people are based primarily on formal rules and regulations. Affection and dependency is confined to the immediate family members. People come together through formal organizations. Law and regulations determine, to a large extent, interpersonal interactions. Relationships are departmentalized and usually based upon functional needs.

Although the reality of today's dominant type of community is gesellschaft, within this structure elements of the gemeinschaft community exists, namely the family. The two categories are not mutually exclusive. This has implications for planning community mental health services.

As amended, the Community Mental Health Centers Act created individual geographic areas for each community mental health center, called "catchment areas". The intent of the legislation was to insure accountability for patient care and to prevent funding for competing mental health centers which could create fragmentation of services and duplication of services; problems the Center's were created, in part, to prevent. Each "catchment area" was to comprise populations of no fewer than 75,000 people and no more than

200,000 people.

These "catchment areas" refer to the gesselschaft type of community but were frequently viewed as a community of shared beliefs, common problems, and homogeneous populations. Research has found that the boundaries of these "catchment areas" came to be defined by the large medical centers which sponsored C.M.H.C. components to their program. Hence, patient care and patient resources were determined, in part, by the organizational network of the sponsoring medical complex, not necessarily upon factors relating to the quality of patient care such as access to services based upon transportation facilities, cultural, racial, or class preferences.

The manner in which these "catchment areas" were created also weakened the possible effectiveness of consumer advisory boards to these facilities. One of the main sources of power for these advisory boards is the extent to which their membership is representative of the area and representative of major power groups within the area. The various groups or organizations which these consumers represent may have different boundaries of membership and influence from the boundaries of the medical complex. This would weaken the effectiveness and power of these community representatives on the advisory boards of community mental health centers. In fact, previous studies in this area have indicated that local consumer advisory boards of mental health centers are not truly representative of their

communities and have limited, if any, input into various local civic and political groups.

Another problem in implementing effective consumer participation based upon the CMHC legislation was the fact that this consumer involvement was mandated. It did not arise from a common philosophy between providers of service and the consumers of the service. This created problems for both groups, resulting in several clashes in various localities between the professionals and consumers over control of the local mental health system. The general acceptance by professionals of consumers as other than passive recipients of service was not realized.

Although the federal legislation mandated consumer participation in these facilities, the implementation was left vague. The legislation did not state the roles and functions of these advisory boards, did not establish criteria of effectiveness and did not establish any specific ongoing monitoring process to ensure community representation on these boards. The term "consumer" itself was nebulous and did not relate, necessarily to the usual meaning of the word, someone who has used a service or product.

In spite of these limitations, many of the local citizens who chose to serve on these boards, may have been genuinely interested in improving the services of the program, but lacked knowledge of the field of mental health to be effective in promoting change or lacked the skills

necessary to navigate proposals through the organizational network.

Need for Formalized Training

Central to the concept of citizen participation is the educational function of the participatory process. To make meaningful choices between options available, one must be knowledgeable of these options and their consequences. The processes by which one achieves change must be known and the power and limitations of one's power within a community or organization must be understood, or energies will be wasted, which can result in apathy. Only with substantive knowledge of the community or organization can one make discriminable evaluations of the effectiveness of the community or organization in meeting the will of the people. Those responsible for fulfilling the will of the people are then held accountable by an informed laity.

For these reasons, several authors have recommended formalized training sessions to help these lay advisory board members function more effectively. Although the various authors do not agree on the specific format of these training sessions, there does exist agreement that certain topic areas need to be explored with the consumer advisory board to a community mental health center. The chief topic areas are training about the Center's budget, the organizational functioning, training in group processes and the need to individualize any such training based on the interests and knowledge base of the advisory board members

and the administration of the individual Center. A model training manual was developed which is contained in Appendix D.

The main components of this manual are:

- Session I: Orientation and Some Aspects of
Group Processes
- Session II: The Budget and Budgetary Processes
of a C.M.H.C.
- Session III: A C.M.H.C.'s Organizational and Decision
Making Processes
- Session IV: Credentialing
- Session V: Program Evaluation
- Session VI: Patient Rights

In addition, a blank copy of the Center's contract with the local funding agency is included in Appendix E.

The extent to which this training manual can be used depends highly on the setting, the administrative response to the training, and the personal characteristics of the individual board. In this project, for instance, it was not possible to obtain a copy of the agency's budget which may be true in training other boards. Also, in this project, the analysis of organismic models of organizations was limited due to the educational background of the group and their interests. Under program evaluation, the discussion on management information systems and P.E.R.T. was limited for the same reasons as well as for time limitations.

In his doctoral dissertation, Caceres examined board training at three Day Care Centers. A social worker who conducted the training limited the intervention to helping the board engage in socialization functions and in fund raising activities for the Centers. Caceres found that the social worker treated them like clients and recommended that the role of the social worker in such a setting should be to act as a technical advisor and an enabler without interfering in their decisions or in their demands on the organization.¹

Alberta Parker engaged in training the advisory boards to neighborhood health centers. Employing the workshop method of training, she focused upon the group developing problem solving techniques and in defining their role relationship to the Center. As a result of the training, she indicated tht the self-confidence of the group increased and they reported increased ability to work together.²

Under Ghetto Medicine, the Community Health Institute developed training programs for the advisory committee of a local general hospital. Five sessions were held discussing such topics as Comprehensive and Preventive Care, Hospital Decision Making and Hospital Economics and National Health Insurance. Using content analysis of the board's minutes on a before-after basis, they reported a major increase in community activity and consumer input. Consumer inputs (communication with the director of the

facility about program operations) increased from 61 to 105 and administrative action on these inputs increased from 22 to 37 after the training sessions.³

The Setting and the Project

This project was an exploratory study involving the training of one consumer advisory board of a community mental health center.

The particular board chosen had an official membership of 25 with an average attendance of 15. The population of its catchment area is 206,000. Based upon the pre questionnaire distributed to the group, six members of the ten who returned the questionnaire were consumers, that is, they resided within the Center's catchment area and were not employees of the facility. The other four were employees. During the training sessions, a total of 17 people attended one or more sessions. (The group met once a month.) In informal discussion with them, it was learned that several of them were also employees of the Center in one of its storefront operations. As a result, this training involved both consumers and staff members of the community mental health center.

Research Findings Concerning First Propositional Statement

The objectives of this project which were tested were:

1. To increase the board's understanding of their role, function, and respon-

sibilities-to be reflected in an increase in the number and types of the board's activities.

2. To improve communication between the board and the administration of the Center.
3. To increase provider responsiveness to concerns of the board.

These objectives were operationalized into two propositional statements. The first one was:

If the advisory board received a training program which clarified their role and activities and educated them in the mental health service delivery system, organizational processes and group decision making processes, then higher levels of consumer participation would occur. The training program is the independent variable and was operationalized to mean the contents of the training session. These are summarized in Chapter IV. The dependent variable, "higher levels of consumer participation" was operationalized to mean a change in the number of activities performed by the advisory board and by changes in the types of the advisory board's activities. Content analysis of the board's minutes on a before-after basis was used to determine the statistical change. In addition, personal interviews were held with board members and a post training questionnaire was administered to determine the participant's perceptions of this change or lack of change.

Prior to the training sessions, the number of consumer initiated topics (the interaction/integration score) was 9 for a period of six months. Following the training, the interaction/integration score was 14 for a period of six months.

Topics initiated by the administrative representatives at the meetings (the direction/control score) was 22 prior to the training. Following the training, it dropped to 11.

This produced an interaction score of .41 prior to training and an interaction score of 1.27 following the training. Prior to training, most topic areas were initiated by the administrative representatives to the advisory board (71%) while following training, this score dropped to 44%. Topics initiated by the consumer members of the board increased from 29% prior to training to 56% following the training sessions. Although the consumer interaction score increased following the training sessions, the increase may have been affected by a crisis that arose.

Besides analyzing the change in the number of interactions initiated by either the consumers or providers in the advisory board meetings, the board's minutes were subjected to content analysis to determine changes in the types of activities of the board in order to test the first propositional statement of this study. This involved a weighing schema developed by Metsch and Veney.

The major change that occurred using this analysis

was the administrative action score. Prior to training, the administration responded to one of the five consumer requests while following the training, the administration responded to all five of the consumer requests.

Research Findings Concerning the Second
Propositional Statement

The second propositional statement of this project stated, "if the advisory board of a mental health center receives a training program which clarifies their role and activities and educates them in the mental health delivery system, then substantive changes will occur in the relationship between the advisory board and the administration of the Center." The training program is the independent variable of this proposition which was operationalized to mean the contents of the training session. The dependent variable, substantive changes in the relationship between the advisory board and the administration of the Center was operationalized to mean all non procedural changes in the relationship between the advisory board and the Center as measured by a content analysis of the minutes.

The results indicated that the number of procedural changes requested by the consumer advisory board to the administration of the Center remained the same after the training sessions as before the training sessions while the number of substantive changes requested before training were three and after training increased, slightly, to five. More

importantly, all three of the substantive requests were not responded to by the administration prior to training while all five substantive requests were responded to by the administration following completion of the training sessions. These changes involved the board meeting with the Director of the Medical Center, opposing his proposed reduction of a storefront and reorganization of the community mental health center. The board also invited officials of the local funding agency to attend their board meeting to discuss proposed funding reductions. The board also requested to attend the exit conference of an independent programmatic audit of the institution.

In general, the board became more directly involved in substantive activities of the facility following the training sessions. However, it must be noted that a crisis arose for the Center. The effects of this crisis in influencing the changes in board participation are unknown. The post questionnaire also supports this conclusion. However, the post questionnaire was received from eleven of the seventeen participants in the training sessions. Of those who attended four or more training sessions, the post questionnaire was received from all but one of these members. Also, the follow-up study was for a six month period following the training sessions. Assuming continuity of board membership, a follow-up study a year later would be advisable to ascertain the statistical change reported in this study. Again, it is speculated that as this board

gained a clearer understanding of their roles and activities, the self-confidence of the group increased which partially accounts for their more direct involvement in issues of the mental health center.

Methodological Limitations

Some of the methodological limitations of these findings are the relatively low response rate involved in these figures and, ideally, an independent check on the author's content analysis judgements to increase reliability of the statistical findings. The experimental group consisted of a total of 17 members who attended the advisory board meetings on a sporadic basis. The composition of the board was another limitation in that several members were employees of the Center. The group also met once a month which introduces many intervening variables. The group also was not representative of its catchment area. There did not occur a major increase in the interaction scores relevant to the first propositional statement. This was not true of the other research reported in this dissertation which used the methodology of content analysis. Yet these other studies did not relate to the major role of the recorder of the sessions' minutes. As a result of this project, this limitation became apparent which is not mentioned in the other research using content analysis reported in this dissertation. The accuracy of the person who takes the minutes of the sessions is a major variable affecting a content analysis of group interaction.

Limitations of Board Training

Certain limitations were learned in training consumer advisory boards of a community mental health center as a result of this project.

The advisory board meetings occur once a month which creates major problems in conducting the training sessions and introduces several intervening variables in attempting to research findings. Attendance is sporadic and the number of people present varies month to month. This seriously hampers the effectiveness of board training held at the time of the board meeting.

Membership on these boards reflect a wide range of educational backgrounds which hinder the training process. With such a wide range of educational backgrounds, the ability of the group to relate to various concepts, their range of interests, their attention span, and their retentive abilities vary considerably. It becomes difficult to establish a common vocabulary.

Due to the nature of a community mental health center's program, the training sessions cannot be geared to the time phases of the Center. Formulation of the budget occurs once a year, programmatic audits may occur at any time during the year, any crisis may occur which will direct the resources of the Center to concentrate on a particular issue. Hence, the retentive abilities and the stability of the group becomes crucial in this type of training.

Role relationships within the group have been formed

prior to the training sessions. As a result, the trainer can be perceived as a threat to areas of expertise held by some other member or members of the group.

Finally, the exercise of citizen participation in such a setting creates conflicts between the power needs of the administration of the Center and the consumer advisory board members. This conflict has to be recognized and dealt with during training which will create tension in the training sessions.

Structural Limitations of Training

In addition, there exists other limitations based upon the structure of these consumer boards. Most of the board members were not members of specific organizations in their community which weakens their power on these boards. Most of those who were members of local community organizations did not perceive a liaison role between the groups.

The consumer role on these boards is ambiguous. The federal legislation creating consumer advisory boards to community mental health centers left the implementation to the system which is provider controlled. Their respective roles, functions, and powers were not spelled out in the legislation.

The board studied in this project was not representative of its community which supports previous research findings in this area. Again, this lessens their power.

In this project, the board's position in the organization and its suprasystem was peripheral. An affiliate institution contained much of the power in this community mental health center and the local advisory board did not have access to this system.

The administration of the Center was not committed to the concepts of citizen participation. The board was used for increasing funding of the Center and fighting proposed cutbacks as they were the "community". Otherwise power was not shared with the board.

In addition, the training involved consumer members of the catchment area as well as professional employees of the Center. This was viewed as a negative. Each group occupied different locations in the hierarchy of the organization and possessed different value orientations. The staff would be corrupted by the system and would present themselves in their professional roles to the lay board members.

In spite of these limitations changes occurred in the advisory board trained in this project. Following the training, the board initiated more significant activities, in part, as they became more aware of their roles and power. The administration of the Center became more responsive to the requests of the board as the board played less of a passive role. Specific ideas to affect the organization were implemented by the board members. This resulted in part due to a crisis but the training also, apparently, was

a factor.

Conclusion

The purpose of a consumer advisory board to a mental health facility is to increase provider responsiveness to the goals and needs of the users of the service, that is, to ensure social accountability.

For these boards to be successful in fulfilling their purpose, they must be valid (representative) and accountable. To achieve this certain changes are necessary in the present system.

At the federal level, the guidelines for citizen participation cannot be generic. A clear statement of their roles, functions, and power needs to be defined. This would increase their legitimacy. If these boards, for instance, were legally responsible for some activities of a mental health facility, then higher levels of consumer participation may result. These boards need a statement of their goals, their responsibilities, and their constraints.

Professionals and schools which train the mental health professionals need to train their students in the potential value of citizen participation. Both consumers and professionals need to develop a better understanding of and respect for each other. Some conflicts will arise but a certain amount of conflict is healthy and can result in the enhancement of services. As long as the professionals operate from the traditional medical model of treatment, an elitist model, then they will view citizen participation as

a useless waste of an organization's resources.

An advisory board to a mental health facility must possess meaningful channels of communication with the organization which it is to advise. Having some administrative liaison person is not sufficient. Rather the board must have access to the various sources of power within an organization so that a meaningful dialogue can occur. Without it, the usual organizational manipulations will occur.

The training process which was used in this project is not recommended. Rather a one or two day training session is needed so that it will become a sequential learning process, not a series of independent sessions with problems of sporadic attendance. In addition, the training should be for the lay advisory board members, not employees of the organization. This could be achieved by giving the consumer recognition and status for completing the training sessions such as a certificate, a luncheon or dinner, and by having some important dignitary attend the function. This process could be repeated with significant changes in board membership.

To help achieve more representative advisory boards, these boards must be viewed by consumers as an access to power. As such they will attract mainly middle class people interested in social mobility. These boards can be a vehicle for them in achieving this and can be viewed as a learning experience for them. At best they can change the

relative power within the mental health facility. This ability to affect decision making also is markedly affected by the organizational context within which participation occurs.

Citizen participation is a painful, time consuming expenditure of resources for an organization. It is also a necessity. The riots of the nineteen sixties demonstrated the effects of not involving citizens in decision making processes when the values of those in power ran counter to the values of the people. It would be a mistake to view that period as something that happened in the past and is now over. The competing values of citizen participation, leadership, and the "expert" are always present within an organization. Exclusion of the role of the others when one has the power can lead to the disintegration of that power and the loss of the positive contributions the competing values can provide to an organization or a society.

FOOTNOTES

1. Mario Caceres, "Citizen Participation: A Conceptual Framework," (D.S.W. dissertation, University of Pennsylvania, 1976).
2. Alberta W. Parker, "The Consumer as Policy-Maker: Issues of Training" Journal of Public Health, 60, (November, 1970).
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APPENDIX A
PRELIMINARY QUESTIONNAIRE TO
ADVISORY BOARD MEMBERS

This instrument was designed to gain certain information about the participants in this study. Several of the questions relate to demographic information such as age (question #6), sex (question #3), extent of formal education (question #5), length of residency in their communities (question #2), occupation (question #4) and social class (questions #7 and #8). These questions were designed to assist the author in preparing the training sessions and were designed to provide data in comparing the experimental group with the control group.

Other questions relate to their knowledge of board processes (questions #10, #11, #12, #13, #14, #15, #16, #17 and #20), the extent of their community involvement (questions #18 and #19) and their motivation for initially joining the board (question #9) along with their motivation for continued membership (questions #21 and #22).

APPENDIX A

Preliminary Questionnaire to Board Members

1. How long have you served on the board? _____
2. How long have you lived in this community? _____
3. What is your sex? Male _____ Female _____
4. What type of work do you do? _____
5. What is the highest grade you achieved in school? _____
6. What is your age? _____
7. Of all the columns below, check only one with a plus (+) and check only one with a minus (-). Check a plus next to the column which best describes the economic segment of most of your board's members. Check a minus next to the one column which best describes the economic segment of the least members of your board.

	(+)	(-)
<u>Professional, Business</u> (such as a doctor, lawyer, certified public accountant, executive or upper managerial level of business)	_____	_____
<u>Subprofessionals</u> (such as teacher, nurse, social worker, lower managerial level)	_____	_____
<u>Foreman, Skilled Laborer</u> (such as an electrician, plumber, mechanic)	_____	_____
<u>Unskilled Laborer</u> above welfare eligibility	_____	_____
<u>Currently on Welfare</u>	_____	_____
8. Are there no members of your board represented in any of these groups? If so, which group (s)? _____
9. What motivated you, initially, to join the board? _____

10. How often are meetings held? _____

11. How are members chosen and replaced? _____

12. Have you personally used the services of the Center? _____
If so, which components? _____

13. Have relatives of yours used the services of the Center? _____
If so, what was their opinion of the service and the program? _____

14. What are your responsibilities as a board member? _____

15. Does the board have by-laws? Yes _____ No _____
16. Does the board have a manual of procedures? Yes _____ No _____
17. For each category, check the box which best describes your working relationship with your mental health facility.

The Board:

Strongly Agree Agree Disagree

Has Control-the Center asks the board to identify some problem, make the key decisions regarding goals and means, and the board has administrative control over the unit.

Has delegated authority - the Center presents a plan to the board and asks the board to make a series of decisions which can be embodied in the plan.

Plans jointly - the Center presents a tentative plan to the board, subject to change and invites recommendations from the board.

Advises - the Center presents a plan and invites questions from the board.

Strongly Agree Agree Disagree

Is Consulted - the Center develops a plan and seeks the support of the board.

Receives Information - the Center develops a plan and announces it to the board.

None - the board is told nothing about some aspect of the program.

18. Are you representative of any group in the community? If so, what kind of group is it? _____

19. Do you consult with community residents or patients of the Center?

20. Does the board have any ongoing contact with the Board of Directors? If so, describe _____

21. What have been the main benefits for you as an advisory board member? _____

22. What do you think the benefits of your services have been to the facility? _____

23. Other comments _____

Thank you

APPENDIX B
OUTLINE OF TRAINING SESSIONS

The following outline was devised to give the reader an overview of the concepts discussed in the training sessions. For a more detailed explanation of each session, the reader is referred to Appendix D.

SESSION I

- I. Orientation and some aspects of group processes.
 - A. Establish a climate - state purpose, objectives of sessions - determine group's resources and resistances, their motivation.
 - B. Establish mutual planning based on group's interest - assess needs of the group - meaningful points of intervention - utilize their experiences by the andragogical processes - role of trainer.
 - C. Establish a contract - goals of sessions and how to attain them - discuss content of sessions and reach mutual agreement.
 - D. Discussion of group problem solving processes - methods to achieve goals of a group and roadblocks which prevent achievement of goals.

SESSION II

II. The Budget of a CMHC

I. Advantages and disadvantages of line by line versus a lump sum budget using a current N.Y.C. budget as an example.

A. The line by line budget.

1. How it achieves accountability, tight control of expenditures and how subject to a final audit.
2. How it can be used to analyze, plan, control and evaluate an organization.
3. It's focus upon inputs of an organization.
4. It's cost per unit analysis.
5. Loss of flexibility - control by funding agency.

B. The lump sum budget.

1. It's focus upon outputs of an organization.
2. Control shifts to the agency.
3. Types of program budgeting - P.P.B.S., cost benefit analysis, systems theory, cost effectiveness analysis, benefit-cost ratios.
4. Problems of this approach.
 - a) power is dispersed in an organization.
 - b) assumes a single hierarchy of values.
 - c) many issues are intractable.
 - d) assumes causal linkage.

SESSION III

III. A C.M.H.C.'s organization and decision-making processes -
strategies for change.

A. The Mechanistic Model.

1. The formal organization.

- a. Assumptions about human nature.
- b. Division of labor.
- c. Specialization of workers.
- d. Hierarchy of authority.
- e. Written rules.
- f. Problems of this approach.

B. The Organistic Models.

- 1. Systems theory.
- 2. Decision-making theory.
- 3. Cybernetics.
- 4. The informal organization.
- 5. Exchange theory.

C. Application of both approaches to understanding the
dynamics of this particular organization.

D. Role of Citizen Participation.

- 1. Power, objectives, goals.
- 2. Possible roles of a community mental health advisory board

IV CREDENTIALING

A. Three Methods.

1. Accreditation.

a. Definition, purpose, process.

2. Certification or Registration.

a. Definition, purpose, process.

3. Licensure.

a. Definition, purpose, process.

B. Trends and Issues.

a. Introduction of consumers in the process.

b. P.S.R.O.'s

c. Role of H.S.A.

Session V

V. Evaluation

I. Program Evaluation

A. Types of Program Evaluation

1. Needs assessment
 - a. socio-economic data
 - b. other demographic data
 - c. services of other mental health agencies in the community.
2. Monitoring - Management Information Systems, Operations Research, P.E.R.T.
3. Service evaluation
 - a. availability
 - b. accessibility
 - c. acceptability
 - d. awareness
 - e. service evaluation-cost, accountability, impact of service
4. Use of Social Indicators

B. Sources of Information

1. Center's annual evaluation plan
2. Levels of service
3. Research studies in Center
4. The client
5. Program description of the Center
6. Census tracts
7. Personnel assessment
8. Patterns of use

II. Role of Advisory Board

- A. To report information and studies to the Center for action.
- B. To receive data from Center for analysis and recommendations.

III. Limitations of Employing Program Evaluations

1. Costs
2. Time
3. Politics

Session VI
VI Patient Rights

- I. History of Major Supreme Court Decisions in this area
 - A. Donaldson versus O'Connor
 - B. Wyatt versus Stickney
- II. Use of Local State's Mental Hygiene Laws
 - A. Legal basis for hospitaliation.
 - B. Length of Stay
 - C. Voluntary versus involuntary admissions, length of stay and treatment.
 - D. Terms of conditional versus unconditional release
 - E. Confidentiality of records
 - F. Incompetency.
- III. Ethical Issues Concerning Patient Rights
 - A. The "expert" versus the rights of the patient to refuse treatment.
 - B. Permission of patient versus outlining options for patient to decide.
- IV. Further Information Needed
 - A. Public education
 - B. Research
 - C. Community based treatment
 - D. Focus of service
- V. Role of Board
 1. How to hospitalize a patient in the community - rights and limitations.
 2. Role of board in protecting patient rights while hospitalized.
- VI. Summation of Training Sessions
 1. Discussion of benefits/limitations
 2. Future plans

APPENDIX C

POST TRAINING QUESTIONNAIRE TO BOARD MEMBERS

This questionnaire was designed solely for the experimental group. It contains both open-ended and close ended questions.

One set of questions relates to their evaluation of each training session involving the categories "poor", "average", , "above average", "excellent" and "not present." These questions are contained in question #1.

Other open-ended questions related to which training sessions were most useful to the participant based on understanding their role, functions and responsibilities as a board member (question #3), their understanding of the mental health delivery system (question #4) and which session or sessions were the most helpful to them personally and why, (question #2).

Another question (#5) elicited their ideas to improve this type of training and one question (#6) elicited any other comments.

Post Training Questionnaire to Board Members

1. How would you rate each of the five sessions in terms of their usefulness to you as a Board Member, providing pertinent knowledge to you as a Board Member and understanding of your role, function and responsibilities as a Board Member. (Feel free to include any comments regarding each session.)

Session I: The Budget and Budgetary Processes:

Poor	Average	Above Average	Excellent	Not Present
☐	☐	☐	☐	☐

Comments: _____

Session II: C.M.H.C.'s Organization and Decision - Making Processes:

Poor	Average	Above Average	Excellent	Not Present
☐	☐	☐	☐	☐

Comments: _____

Session III: Credentialing, Certification, and Licensure:

Poor	Average	Above Average	Excellent	Not Present
☐	☐	☐	☐	☐

Comments: _____

Session IV: Program Evaluation:

Poor	Average	Above Average	Excellent	Not Present
☐	☐	☐	☐	☐

Comments: _____

Session V: Patient Rights:

Poor	Average	Above Average	Excellent	Not Present
☐	☐	☐	☐	☐

Comments: _____

2. Which session(s) proved most helpful to you and why.

3. Which session(s) proved most helpful in understanding your role, functions and responsibilities as a Board Member. Indicate reason why.

4. Which session(s) proved most helpful in understanding of the mental health delivery system and why.

5. What ideas do you have to improve this type of training for other community advisory boards?

6. Any other comments?

Thank you

Appendix D

Training Manual

A Manual Developed For Training Consumer Advisory Board
Members to a Community Mental Health.

Session I
Orientation and Some Aspects
of Group Processes

Purpose:

To establish a contract between the trainer and the members of the board as to the purpose, objectives and limitation of this type of training.

- A. Discuss with them their interests, concerns and view as to present board functioning.
- B. Describe how the training may alleviate some of these problems.
- C. At the same time, attempt to determine the board's resources and resistances.
- D. Involve the board in planning the sessions - topics to be covered, time frame, length of sessions. Attempt to reach mutual agreement on these issues.
- E. Possible topics of interest:
 - 1. The budget and budgetary processes.
 - 2. The organizational decision-making processes
 - 3. Credentialing.
 - 4. Other topics of interest.
- F. Explain to group the purpose of the preliminary questionnaire and have the group members complete it - explain meaning of questions.
- G. Request from the group access to the board's minutes and explain purpose. Indicate to the group that the content of the sessions will be influenced by the current level of the board's functioning and the analysis of the preliminary questionnaire.
- H. Establish firmly the date, time and topic area of next meeting.

Strategies for the initial session:

- A. As much as possible, focus upon the immediate interests of the group.
- B. Be realistic as to what can and cannot be accomplished.
- C. Use a common vocabulary.

- D. Put people at ease - the climate of the initial meeting is essential.
- E. Remain flexible.

Initial Assessment of the Group:

- A. Elicit their conception as to their purpose, role and functions.
- B. Discuss interventions strategies the group has used to achieve change - what has worked and what has failed and the reasons for this.
- C. Discuss their relationship with the administration - areas of mutual cooperation and areas of conflict.
- D. Discuss their knowledge of and personal involvement in the suprasystem of the agency and their community.

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4. Ann L. Greer, "Training Board Member of Health Planning Agencies," in Public Administration, Vol. 91, No. 1, Jan.-Feb., 1976).
5. Orientation Manual for Citizen Boards for Federally Funded Community Mental Health Centers, U.S. Department of Health and Human Services, Rockville, Maryland.
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Session II

The Budget and Budgetary Processes of a C.M.H.C.

Purpose: To explain to the group how to understand the budget of a C.M.H.C. and how it relates to the organizational matrix.

- A. The line by line budget.
 1. A plan of expenditures from the coming fiscal year.
 2. How it achieves accountability, control of expenditures and how it is subject to audit-major control in funding sources and, hence, loss of some flexibility by the agency.
 3. How to examine budget to determine priorities of an organization and the organization's true goals.
 4. Explain items in Personal Services and Other than Personal Service and how these costs are allocated.
 5. How management can use it to analyze, plan, control and evaluate an organization using concepts from operations research.
 6. Its focus upon the inputs of an organization.
- B. The Lump Sum Budget
 1. Focus placed on outputs of an organization - unit costs, cost efficiency, benefit-cost ratios.
 2. Program, Planning, Budgeting Systems (P.P.B.S.) - its focus on how many units of a service can be produced with X number of dollars to service X number of people. Its objectives-taxonomic, analytic and projective.
 3. Problems of P.P.B.S.
 - a. Assumes rational within and a single set of values with the hierarchy.
 - b. Many issues are intractable.
 - c. Assumes casual linkages within the organization.
 - d. Discuss Lindblom and Etzioni's concept of "muddeling through"-organizational change resulting from a bargaining process between various groups vying for power.
 4. Control shifts to the agency - accountability placed on product (units of service), not process.
- C. The Agency's budget.

1. Explain function of the cross-walk - relate the line by line budget to unit costs.
2. Explain levels of service commitment as it relates to program structure and unit cost.
3. Explain procedures and levels of authorization in the use of accruals.
4. Explain procedures and levels of authorization to shift accruals from the "personal service" category to the "other than personal service" category.
5. Indicate areas of flexibility within the budget and areas of inflexibility.
6. Explain function of third part payments.
7. Explain possible role of board in preparation and approval of agency's budget.

Strategies for the session:

1. If possible, bring the Center's actual budget to discuss at the session and distribute copies.
2. If not feasible, distribute copies of a blank budget used by the Center.
3. Relate issues of line by line budget and lump sum budget to actual lines of the sample budget.
4. Elicit questions from the group on all lines and items contained in the budget.
5. If the Center's actual budget can be obtained, analyze priorities of the program, methods of cost control and unit cost analysis and possible methods of evaluating the program.

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3. Wedel, Kenneth R., "Government Contracting for Purchase of Service" in Social Work, Vol. 21, No. 2, March, 1976, pages 101-105.
4. Worthley, John, "P.P.B. Dead or Alive" in Public Administration Review, No. 4, July-August, 1974, pages 392-394.

Session III
A C.M.H.C.'s Organizational and
 Decision-Making Processes -Strategies for Change

Purpose: To acquaint the group with some aspects of organizational theory as it relates to their role as advisory board members. (The Level of presentation will be strongly affected by the educational level of the group.)

Outline

- A. The traditional mechanistic model of organization- its assumptions about human nature, its division of labor, specialization of workers, focus upon written rules and the hierarchial chain of authority.
- B. Problems with this analysis.
 1. Discuss major findings of studies on the informal network within organizations.
 2. Focus on major components of systems theory and how a community advisory board relates to, is influenced by and can influence other parts of the system.
 - a. Focus on suprasystem as the road of influence for the advisory board.
 - b. Role of local community planning boards.
 - c. Communication between the board and other components of the Center.
 3. Roles of a community mental health advisory board.
 - a. The liaison role - informational between Center and community, the educational role between the Center and the community, how this role can lessen alienation between the two groups.
 - b. A political action body - can develop community support for the Center's programs.
 - c. To recruit volunteers.
 - d. Potentially, a major method of protecting patient's rights.
 - e. A preventive role - need for family and community involvement in treating mental illness.
 4. Other organistic modals of organizational analysis and possible application in their setting.
 - a. Decision-making theory.
 - b. Exchange theory.
 - c. Cybernetics.
 - d. The informal organization.

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Session IV

Credentialing

Purpose: To help the group become more knowledgeable regarding the types, purposes and regulatory power of different types of accreditation and to note trends and issues in these processes. The role of the advisory board is stressed in each area of credentialing.

- A. Accreditation - a non-governmental process whose purpose is to establish standards, create goals for the institution and validate the institution - performed by Joint Committee on Accreditation of Hospitals - role of advisory board in exit interview - helps create accountability.
- B. Certification or Registration - a non-governmental body validates a person and sets standards of performance - based on education, work experience and possibly a test.
- C. Licensure - a police power - gives persons a right to engage in a certain practice which may be withdrawn sets minimum standards with possible disciplinary action - may issue an operating certificate for a given time period.
- D. Trends and Issues
 - 1. Role of consumer in these processes and how this role is increasing.
 - 2. P.S.R.O.'s - a medical peer review process - required for Medicaid and Medicare reimbursement.
 - 3. Role of Health Systems - Agency - their development and powers - purpose is to curtail costs and seek new ways to improve services and the quality of care - majority are consumers.

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Session V
Program Evaluation

Purpose: To acquaint the advisory board with the various types of program evaluation and their role in the Center's program evaluation.

- A. Define Program Evaluation - to collect and analyze data to determine the relative value of a program.
 1. Role of Board - an action body in this process.
 2. Areas of study - can study structure, process or outcome.
- B. Describe types of program evaluation
 1. Needs assessment of the area - use census tracts and other studies to determine demographic data, studies of usage, and services of other mental health providers in the area.
 2. Monitoring - describe uses of M.I.S., O.R., P.E.R.T. describe how P.E.R.T. can be used by the board as an internal tool in their group processes.
 3. Describe types of service evaluation.
 - a. availability (presence/absence)
 - b. Accessibility - ease of obtaining services, location, type, special needs of the clients.
 - c. Acceptability - such as a retrospective client satisfaction study.
 - d. Awareness - test out if community is knowledgeable of a service.
 4. Explain use of social indicators to determine program need and program effectiveness.
- C. Role of Advisory Board
 1. An action body in the program evaluation of the Center.
 2. Establish committee on evaluation.
 3. Describe importance of board in studying the Center's program from the prospective of the client.
 - a. can discuss program with the client such as why they did not keep appointments.
 - b. can conduct a follow-up questionnaire to the clients of the service.
 - c. can suggest areas of program to be studies for evaluation.
 - d. can submit board's findings to the Center
 - e. board's program evaluation can be continuous while Center's evaluation are usually time-limited.
- D. Discuss limitations of program evaluation - time, cost, politics.

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Maryland, 1976.

Session VI
Patient Rights

Purpose: To inform the group of the rights of patients, their families and community in the treatment of mental illness. The role of the advisory board is stressed in these issues.

- A. Describe major Supreme Court decisions in this area and the abuses they attempted to correct.
 1. Donaldson versus O'Connor - established that non-dangerous mental patients have the right to discharge if they were not receiving treatment in a mental hospital.
 2. Wyatt versus Stickney - set minimum standards of treatment and ensured due process for patients.
 3. Explain difference between a "narrow" and "broad" Supreme Court ruling.
- B. Bring copy of local State's Mental Hygiene Laws to the session.
 1. Discuss local State's legal basis for involuntary admission to a psychiatric hospital, length of stay and treatment - explain terms of conditional versus unconditional release - explain rules regarding confidentiality of records and determination of "incompetency" - differentiate "incompetency" from mental illness.
- C. Discuss ethical issues involved in "involuntary" admission and treatment - the values of the "expert" - discuss concept of how outlining the options of treatment to the patient, their implication and the consequences of the patient's choice will lead to greater cooperation by the patient.
- D. Discuss need for further information in this area - public education, research, the need and benefits of community based treatment and the concept of "focus of service" - the patient enters the system at his highest level of functional capacity and at the level which will minimize dependency and maximize independent living.
- E. Discuss role of advisory board in public education and protecting patient rights while hospitalized.
 1. Ensure statement of patient rights is visible in the hospital, especially on the inpatient unit and the intake unit.
 2. Action that can be taken to hospitalize an "acting-out" person in the community.
 3. Role of educating other community residents in these areas.

E. Summation of Training Sessions.

1. An open discussion with the group on the benefits and limitations of the training sessions.
2. Any plans for follow-up or further information needed.

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APPENDIX E

FORMS REQUIRED FOR STANDARD AND 100%
CHAPTER 620 CONTRACTS

DMHHRAS - 240
(12-83)

DEPARTMENT OF MENTAL HEALTH
MENTAL RETARDATION AND
ALCOHOLISM SERVICES

BUDGET SUMMARY

(Date Prepared) _____

Agency _____ Contract No. _____

Period of Contract _____

	Previous Budget FY _____	New Budget FY _____
I PERSONAL SERVICE (PS) (#100)		
Psychiatrists (A)	\$ _____	\$ _____
Psychologists (B)	_____	_____
Psychiatric Social Workers (C)	_____	_____
Other Professionals (D)	_____	_____
Other Direct Service Personnel (E)	_____	_____
Administrative & Support Personnel (F)	_____	_____
TOTAL PERSONAL SERVICE (PS)	\$ _____	\$ _____
II OTHER THAN PERSONAL SERVICE (OTPS)		
Equipment (#200)	\$ _____	\$ _____
Supplies & Materials (#300)	_____	_____
Travel Expenses (#401)	_____	_____
Rent (#402)	_____	_____
Communication (#403)	_____	_____
Light & Power (#410)	_____	_____
Insurance (Fringe Only) (#412)	_____	_____
Other (#499)	_____	_____
TOTAL OTHER THAN PERSONAL SERVICE (OTPS)	\$ _____	\$ _____
III GROSS CONTRACT AMOUNT (I plus II)	_____	_____
IV BUDGETED ACCRUALS	_____	_____
V ADJUSTED GROSS CONTRACT AMOUNT (III minus IV)	_____	_____
VI BUDGETED APPLICABLE INCOME		% of _____
% of \$ _____ Total =	\$ _____	\$ _____
(Estimated Fees)		Total = \$ _____
VII NET CONTRACT AMOUNT (V minus VI)	\$ _____	\$ _____
VIII BUDGETED AGENCY CONTRIBUTION	_____	_____
IX ADJUSTED NET CONTRACT AMOUNT (VII minus VIII)	_____	_____
BUDGETED CITY CONTRIBUTION	\$ _____	\$ _____
BUDGETED STATE CONTRIBUTION	_____	_____
BUDGETED FEDERAL CONTRIBUTION	_____	_____

DMHMRAS - 340
(12-83)

DEPARTMENT OF MENTAL HEALTH
MENTAL RETARDATION AND
ALCOHOLISM SERVICES

VOLUNTARY AGENCY BUDGET ESTIMATE FOR MENTAL HYGIENE SERVICES

Agency _____ (Date Prepared) _____
Period of Contract _____ Contract No. _____

		ESTIMATED COSTS
I	<u>PERSONAL SERVICE (PS)</u>	
	1. PS In-Contract	\$ _____
	2. PS Out-of-Contract	_____
	Total PS	\$ _____
II	<u>OTHER THAN PERSONAL SERVICE (OTPS)</u>	
	1. OTPS In-Contract	\$ _____
	2. OTPS Out-of-Contract	_____
	Total OTPS	\$ _____
III	TOTAL ESTIMATED COSTS (sum of I + II)	\$ _____

		BUDGETED ACCRUALS
IV	A. Budgeted Accruals In-Contract	\$ _____
	B. Budgeted Accruals Out-of-Contract	_____
	TOTAL BUDGETED ACCRUALS	\$ _____

		ESTIMATED REVENUE	
V.	Client-Related Income	Average Rate	X Projected # of Visits= Annual Amount
	1. Medicaid-Individual	_____	_____
	2. Medicaid-Group	_____	_____
	3. Medicare	_____	_____
	4. Self-Pay	_____	_____
	5. Third Party Insurance	_____	_____
	6. Sale of Goods	_____	_____
	7. OVR	_____	_____
	8. SEP	_____	_____
	9.	_____	_____
	10.	_____	_____
		Sub-Total	\$ _____

VI	Grants, contracts with government sources	
	A. City (Specify Department)	
	1. _____	\$ _____
	2. _____	_____
	3. _____	_____
	B. State (Specify Department)	
	1. _____	\$ _____
	2. _____	_____
	3. _____	_____
	C. Federal (Specify Department)	
	1. _____	\$ _____
	2. _____	_____
		Sub-Total \$ _____

VII	Agency Contribution	
	A. Fund Raising Activities	\$ _____
	B. Endowment	_____
	C. Gifts	_____
	D. Foundation Support	_____
	E. _____	_____
		Sub-Total \$ _____

VIII	Total Estimated Revenue (V + VI + VII)	Total \$ _____

Note: Total Estimated Revenue (item VIII) plus
Total Budgeted Accruals (item IV) must equal
Total Estimated Cost (item III)

DMHMRAS - 340 Addendum
(12-83)

DEPARTMENT OF MENTAL HEALTH,
MENTAL RETARDATION AND
ALCOHOLISM SERVICES

REVENUE ALLOCATION METHODOLOGY

A. Derivation of Budgeted Income Application Factor

Gross Contract Amount \$ _____
divided by
Total Program Budget \$ _____ (Same as 240,
New Budget)

B. Calculation of Budgeted Applicable Income

Source of Income	Calculation (e.g. visits x rate)	Agency Income	Applied Percent	Budgeted Applicable Income
(1) Medicaid				
(2) Medicare				
(3) Self-Pay				
(4) Third Party Insurance				
(5) Sales of Goods (produced by patients)				
(6) State Grant: OVR				
SEP				
Other				
(7) Federal Grant (specify)				
(8) Chapter 620				
(9) Other Income (specify)				
Total		\$		\$

C. Method of Reporting Applicable Income

☐

Cash Basis

☐

Other

Note: Any departure from the cash basis method of reporting Applicable Income requires prior written Department approval.

DMHMRAS - 180a
(12/83)

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND ALCOHOLISM SERVICES
ITEMIZED SCHEDULE OF CONTRACTUAL SERVICES-PERSONAL SERVICE SECTION

Page No. _____ of _____

Name of Facility _____

Date Prepared _____

Name of Agency _____

Contract No. _____

Period of Contract _____

Position No.	Name of Employee Job Title; Last approved Salary Rate and its Effective date	Projected Salary Rates During Contract Period		Actual Salary Payroll Rate. (Indicate actual gross rate paid per week, bi/weekly, month, hour, session, etc. on salaries in Column 3)	Total Gross Salary During Contract Period.	Total Annual Work Period (Indicate number of weeks/year and hours/week or number of sessions/year and hours/session)	Contract Work Period. (Indicate percen- tage of total annual work period to be in contract; plus wks/yr. and hours/wk. or sessions/year and hours/session) Subtotal by Discipline	Total Dollar Amount Applied to Contract Subtotal by Discipline	Remarks (if necessary)
		Annual Rate	Effective Date						
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
			7-1-8						
			7-1-8						
			7-1-8						
			7-1-8						
			7-1-8						
			7-1-8						

Page No. ____ of ____

Date Prepared _____

Contract No.

Period of Contract _____

[illegible]

DMHMRA5 - 180b
(12-83)

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND ALCOHOLISM SERVICES

Page No. _____ of _____

ITEMIZED SCHEDULE OF CONTRACTUAL SERVICES-OTHER THAN PERSONAL SERVICE SECTION

Name of Facility _____

Date Prepared _____

Name of Agency _____

Contract No. _____

Period of Contract _____

GROUP BY CODE NUMBERS AND TITLES		Total Estimated Cost for Contract Year	Percent of Total Cost Applied to Contract	Amount of Total Cost Applied to Contract (Total by Codes)	Itemization of Estimated Costs	Allocation Methodology (Indicate methodology used to allocate costs for each OTPS category. If direct cost, please specify).
Code Number	Code Titles (Followed by Sub-Titles)					
(1)	(2)	(3)	(4)	(5)	(6)	(7)

ITEMIZED SCHEDULE OF FACILITIES

Name of Agency _____

Date Prepared _____

Period of Contract _____

Contract No. _____

Note: List all sites occupied by Agency for provision of Contract Services

Address of Site (Including Borough & Zip Code) (1)	Landlord's Name & Address (Including Borough & Zip Code) (2)	Annual Rent (For rented sites) (3)	No. of Square Feet (4)	Cost per Square Foot (5)
(1)		\$	_____sq. ft.	\$
(2)		\$	_____sq. ft.	\$
(3)		\$	_____sq. ft.	\$
(4)		\$	_____sq. ft.	\$
(5)		\$	_____sq. ft.	\$

DMHMRAS - 180c
(12-83)

DEPARTMENT OF MENTAL HEALTH
MENTAL RETARDATION AND
ALCOHOLISM SERVICES

LIST OF BOARD OF DIRECTORS

PLEASE PROVIDE CURRENT INFORMATION

Name of Agency _____ Date Prepared _____

Period of Contract _____ Contract No. _____

Name Address Telephone No.

LINE BUDGET-PROGRAM BUDGET CROSSWALK-PERSONAL SERVICE SECTION

Name of Facility _____

Date Prepared _____

Name of Agency _____

Contract No. _____

Period of Contract _____

Position Number	Name of Employee	Contract Work Period (Form 180a, Column 8)	DollarAm't Applied to Total Con- tract. (Form 180a, Column 9)	PROGRAM UNITS														
				(A)			(B)			(C)			(D)			(E)		
				Work Period	%	Amount	Work Period	%	Amount	Work Period	%	Amount	Work Period	%	Amount	Work Period	%	Amount
(1)	(2)	(3)	(4)															

DMHMRAS - Annex A
(12-83)

DEPARTMENT OF MENTAL HEALTH,
MENTAL RETARDATION AND
ALCOHOLISM SERVICES

ANNEX A

I. AGENCY

- A. Full name, principal business address and telephone number.

- B. Name and address (if different from A above) of Agency's designee for notices pursuant to this Agreement.

- C. Address (if different from A above) where Agency's books and records are maintained.

- D. Names of Executive, Medical, and/or Program Director and time devoted to Contract Services pursuant to this Agreement.

- E. Commencement and termination dates of this Agreement.

- F. Contract Services shall be primarily available to persons residing in the following area of New York City:

II. FACILITIES/LOCATIONS

Give the following information for each location: a) name of facility, b) address, c) telephone number, d) person in charge, and e) days and hours when Contract Services are available.

DHHRAS - Annex A
(12-83)

-2-

2 of 2

III SERVICES

- A. Type of service offered (e.g. outpatient clinic, inpatient service, psychiatric rehabilitation service or any service dictated by generally accepted standards of clinical care).
- B. Disability groups served (mentally ill, mentally retarded and developmentally disabled or alcoholic).
- C. Population served (age, sex, etc.)
- D. Level of service (number of patients, visits, patient days, etc.) or staff time for each type of service and patient.

SEE ATTACHED FORMS

LEVELS OF SERVICE COMMITMENT

Program Unit _____ Name of Facility _____ Date Prepared _____
 (Include State Certification Category)
 Total P.S. \$ _____ Name of Agency _____ Contract No. _____
 Total O.T.P.S. \$ _____ Facility Code _____ Period of Agreement _____
 Gross Amount \$ _____ Unit Code _____
 Adjusted Gross Am't. \$ _____

I Personal Service Category	II No. of Full- time Equivalent Staff	III Annual Amount of Hours Paid for	IV Estimated Annual Amount of Hours Worked	Projection of Monthly Visits (or Patient days)			
				July _____	Visits Nov. _____	March _____	
				Aug. _____	Dec. _____	April _____	
				Sept. _____	Jan. _____	May _____	
				Oct. _____	Feb. _____	June _____	Total Visits _____
<u>DESCRIPTION OF PROGRAM UNIT</u>							
A							
B							
C							
D							
E							
F							
Total							

DMHMRAS - 600a
(12-83)

DEPARTMENT OF MENTAL HEALTH
MENTAL RETARDATION AND
ALCOHOLISM SERVICES

AGENCY NAME _____

CONTRACT NO. _____

PROGRAM UNIT _____

Total P.S. Amount	_____
Total O.T.P.S. Amount	_____
Gross Amount	_____
Accruals	_____
Adjusted Gross Amount	_____
Income	_____
Net Amount	_____

UNITS OF SERVICE COMMITMENT

<u>Month</u>	<u>Calculation</u>	<u>Units of Service</u>
July		
August		
September		
October		
November		
December		
January		
February		
March		
April		
May		
June		
Total		

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(12-83)

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND ALCOHOLISM SERVICES

STAFF HOURS

Reporting Period from _____ to _____

Contract No.

3 Boro Code

4. Facility Code

5. Unit Code

Name of Facility _____

8. Type

a. M.H.

b. M.R.

c. ALC.

Name of Unit _____

9. Age

a. CHILD

b. ADOL

c. ADULT

d. GER

DISCIPLINE OF STAFF	10. FUNDED STAFF HOURS			11. STAFF HOURS NOT FUNDED BUT CONTRIBUTING TO COMMITMENT			12. VOLUNTEER STAFF HOURS CONTRIBUTING TO COMMITMENT			13. TOTAL COMMITTED STAFF HOURS WORKED (10C+11C+12C)	14. TOTAL NON-FUNDED STAFF HOURS WORKED	15. GRAND TOTAL (13 + 14)
	a. Direct	b. Indirect	c. Total hrs. Worked	a. Direct	b. Indirect	c. Total hrs. Worked	a. Direct	b. Indirect	c. Total hrs. Worked			
PSYCHIATRISTS.												
PSYCHOLOGISTS												
SOCIAL WORKERS												
OTHER PROFESSIONALS												
OTHER DIRECT SERVICE STAFF												
ADMINISTRATIVE AND SUPPORT STAFF												
TOTAL												

NYC-55
(12-83)

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND ALCOHOLISM SERVICES
STAFF HOURS AND NUMBER OF SESSIONS BY DISCIPLINE BY DIRECT SERVICE MODALITY IN CLINICS

1. Reporting Period from _____ to _____

2. Contract No. 3. Boro Code 4. Facility Code 5. Unit Code

6. Name of Facility _____ 8. Type: a. MH b. MR c. ALC

7. Name of Unit _____ 9. Age: a. Child b. Adol c. Adult d. Ger

Staff Hours and Numbers of Sessions by Discipline	10. Individual Therapy	11. Group Therapy	12. Family Therapy	13. Collateral Contacts	14. Chemotherapy Only	15. Diag. and Evaluation	16. Phone Contacts	17. Other Direct	18. Total
19. Psychiatrists									
Hours									
25. No. of Sessions									
20. Psychologists									
Hours									
25. No. of Sessions									
21. Social Workers									
Hours									
25. No. of Sessions									
22. Other Professionals									
Hours									
25. No. of Sessions									
23. Other Direct Service Staff									
Hours									
25. No. of Sessions									
24. Administrative & Support Staff									
Hours									
25. No. of Sessions									
Total									
Hours									
25. No. of Sessions									

NYC-55
(12-83)

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND ALCOHOLISM SERVICES
STAFF HOURS AND NUMBER OF SESSIONS BY DISCIPLINE BY DIRECT SERVICE MODALITY IN CLINICS

1. Reporting Period from _____ to _____

2. Contract No. 3. Boro Code 4. Facility Code 5. Unit Code

6. Name of Facility _____ 8. Type; a. MH b. MR c. ALC

7. Name of Unit _____ 9. Age: a. Child b. Adol c. Adult d. Ger

Staff Hours and Numbers of Sessions by Discipline	10. Individual Therapy	11. Group Therapy	12. Family Therapy	13. Collateral Contacts	14. Chemotherapy Only	15. Diag. and Evaluation	16. Phone Contacts	17. Other Direct	18. Total
19. Psychiatrists									
Hours									
25. No. of Sessions									
20. Psychologists									
Hours									
25. No. of Sessions									
21. Social Workers									
Hours									
25. No. of Sessions									
22. Other Professionals									
Hours									
25. No. of Sessions									
23. Other Direct Service Staff									
Hours									
25. No. of Sessions									
24. Administrative & Support Staff									
Hours									
25. No. of Sessions									
Total									
Hours									
25. No. of Sessions									

Form LS 2C (MH-12-80)

MONTHLY STATISTICAL REPORT FOR UNIT

(Local Providers Certified and/or Funded by OMH)

OFFICE OF MENTAL HEALTH

Submit Form LS 2C (MH) within 15 Calendar Days of End of Month. Send Original to IQCC Statistics at Department, 12 Pratt Street, Albany, N.Y. 12242. Send a Copy to County Services Board or NYC-DHS/RAS. If there are Insurance Data, also Send Copy to Insurance Health Plan, Inc., c/o County Board of Health, at Facility.

Facility Name		Facility Code		Unit Name		Unit Code		Month					
STATISTICS		TOTAL Enrolled 1-2 Admitted 3-4 Discharged 5-6 Deceased 7-8 Total 9-10 (1)	PRIMARY DISABILITY								VISITS TO NATURAL SETTING (12)		
			Mental Illness				Mental Retardation and Developmental Disabilities					Alcoholism & Alcohol Abuse	
			Chronic 609	Acute 12	Local Assistance 14	Other 15	Chronic 609	Acute 12	Local Assistance 14	Other 15		Local Assistance 14	Other 15

A. STATISTICAL SUMMARY - If Number of Patients on Rolls at Beginning of Month = Discharge from Emergency Room (Line 4) from Previous Month, Report Show Adjustments on Form LS 2C (MH) and Enter Adjustments in First Line of Data Line 1 on this Report

1	No. of Patients on Rolls, Beginning of Mo.										
2	No. of Additions to Unit During the Mo.										
3	No. of Removals from Unit During the Mo.										
4	No. of Patients on Rolls, End of Mo.										
5	No. of Individual Patients with one or More Visits or Patient Days During YR (Excludes Individuals Screened But NOT Admitted)										

B. RESIDENTIAL PROGRAMS (PATIENT DAYS)

6	Inpatient										
7	Community Residence										

C. NON-RESIDENTIAL PROGRAMS (VISITS)

8	Clinic Treatment - Brief Visits (< 30 min.)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
9	- Clinic Visits (30 min. or more)												
10	- Group Visits (If Visit includes Group and other Procedures, Count as Clinic Visit, NOT as Group Visit)												
11	Day Treatment - Less than 1/2 Day Visits (< 3 hrs.)												
12	- 1/2 Day Visits (3 - < 5 hrs.)												
13	- Full Day Visits (5 hrs. or more)												
14	Continuing Treatment - Less than 1/2 Day Visits (< 3 hrs.)												
15	- 1/2 Day Visits (3 - < 5 hrs.)												
16	- Full Day Visits (5 hrs. or more)												
17	Certified Work Activity/Sheltered Workshop - Less than 1/2 Day Visits (< 3 hrs.)												
18	- 1/2 Day Visits (3 - < 5 hrs.)												
19	- Full Day Visits (5 hrs. or more)												
20	Classroom Education - Visits - Preschool (< 5 Yrs of Age)												
21	- School (5 Yrs to < 22 Yrs of Age)												

D. SPECIAL PROCEDURES

22	Pre-Admission Screening - Visits	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
23	Non-Inpatient Crisis Services (Include in Part C above)												

24	CASE MANAGEMENT - No. of Staff Hours - Direct												
25	- Indirect												
26	No. of Patient or Collateral Visits - Included also in Part C above												
27	- Not Included in Part C above												
28	- No. of Individuals Served												

29	Homemaker Services - Staff Hours												
30	Housekeeping Services - Staff Hours												
31	Prevention, Consultation and Education - Staff Hours												
32	Outreach - Contacts												
33	Patient Transportation - No. of Patient Trips												

E. OTHER		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
34	Other - Specify												
35	Other - Specify												

Completed By: Type or Print Name and Title	Telephone: Area Code & No.	Date
	1	

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