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DEVELOPMENT OF A SCALE TO MEASURE THE ATTITUDE TOWARD CITIZEN PARTICIPATION IN COMMUNITY MENTAL HEALTH CENTER BOARDS

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DEVELOPMENT OF A SCALE TO MEASURE THE ATTITUDE TOWARD CITIZEN PARTICIPATION IN COMMUNITY MENTAL HEALTH CENTER BOARDS

By

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ABSTRACT

DEVELOPMENT OF A SCALE TO MEASURE THE ATTITUDE TOWARD CITIZEN PARTICIPATION IN COMMUNITY MENTAL HEALTH CENTER BOARDS

By

Edward A. Oxer

The concept of citizen participation has been a central theme in American democracy and politics. Community institutions and agencies, as part of the fabric of American democracy, have been influenced significantly by the underlying philosophical base of community involvement and local control.

Large State mental hospitals that were for many communities the exclusive providers of inpatient mental health services in the early 1950s with the impetus of a strengthened mental health policy at the State and Federal levels gave way to the "third revolution" in psychiatry; that of community mental health.

Local communities were to be served by locally operated, community-based mental health services, but the problem of defining the community's boundaries and assuring suitable citizen input, representative of the community, was greater than anticipated by the planners. The controversy soon became polarized around citizen participation versus citizen control.

Edward A. Oxer

The purpose of this study was to develop an instrument to measure the attitude toward citizen participation in Community Mental Health Center boards. The importance of this study is evident for any community mental health center program that does not develop a suitable mechanism for insuring adequate community involvement, so as to relate itself to community needs, will soon be suffering from a lack of community support, often with financial and political consequences.

A series of 80 statements was developed from an extensive review of the citizen participation in mental health literature. Seven factors or subscales were hypothesized and the 80 statements were scaled in the Likert format. Seven experts in the field rated the 80 items and predicted directionality of the items, as well as the factors into which the items fell. Items were reviewed for content validity and criterion groups were also suggested from an expanded list of groups concerned with citizen participation in community mental health. A total of 45 items and six factors received sufficient support from the experts to be included in a pilot of the scale. The 45-item scale was administered to a pilot group of 50 with a 15-item semantic differential scale and a five-item control over decision making scale included as criterion measures. The final stage of instrument development involved construct validation in which

several groups such as community mental health services board members, community mental health center staff and clients completed the scale in terms of their view of citizen participation.

Strong correlations were expected between the cumulative scores for each group and the criterion measures, as well as certain of the demographic characteristics. Significant differences were expected among groups, which should indicate that the scale has the ability to discriminate between those in favor of a strong citizen role in CMHC decision-making and those who are not.

A reasonably reliable 30-item scale was developed which has the ability to differentiate between groups with varying views of citizen participation. Several weak relationships were found between demographic characteristics and the scale which suggested that those who were older, more educated and at a higher income level support a strong citizen role in decision-making. Other data suggest that those in favor of citizen participation see community leaders and potential consumers rather than clients and mental health professionals as being able to play a strong role in CMHC decision making. Minorities and community mental health board members were in favor of a strong citizen role. Clients and parents of clients were found to be aligned with professionals in non-support of a strong role for citizens in CMHC decision making.

To

My Wife, Tina

and

My Sons, Adam and Jeremy

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Introductory Statement

> Government must be kept open. If we intend to rebuild confidence in the government process itself, policy must be shaped through the participation of Congress and the American people.
>
> Jimmy Carter
> (Community Services Administration, 1978)

The concept of citizen participation has been central to American democracy and politics. Community institutions and agencies, as part of the fabric of American democracy, have been influenced significantly by the underlying philosophical base of community involvement and local control.

Large state mental hospitals that were for many communities the exclusive providers of inpatient mental health services in the early 1950s gave way, with the impetus of a strengthened mental health policy at the federal and state levels, to the "third revolution" in psychiatry: community mental health. State governments that operated the mental hospitals responded to legislative forces, as well as to citizen groups calling for a

substantial portion of the mental health budget to be used in operating and contracting for community services such as outpatient clinics, day treatment, halfway houses, 24-hour emergency services, inpatient services, and prevention programs. The Federal government's initial role in this was via the Community Mental Health Center's Act (PL 88-164 of 1963) which funded state planning grants to the designated state mental health authority. Service districts, or catchment areas, ranging in size from 75,000 to 200,000 population were called for as a way of locating services in close proximity to local "communities." But the problem of defining the local community's boundaries and assuring suitable citizen input, as well as its effectiveness, was greater than anticipated by the National Institute of Mental Health (NIMH) plannners. The controversy soon became polarized around citizen participation versus citizen control. Who are the true representatives of the residents of the community? How should the "community" be defined? Connery (1968) pointed out that the Federal insistence on a population limit for community mental health centers was unrealistic. "The guiding principle should not be size but that the governmental unit sponsoring it be a viable one in terms of an adequate tax base and leadership supply. The unit must have a present political reality" (Connery, 1968, p. 507).

The NIMH Community Mental Health Center (CMHC) concept addressed the issue of community involvement without specific regard to the local political realities across the United States. The Federal Program of Community Mental Health Centers (CMHCs) is based on the premise that in order for a CMHC to be successful, it must be responsive to the viewpoints and problems of local communities. For this reason, the following mandate was included in the Community Mental Health Centers' Amendments of 1975, Public Law 94-63, Section 201(c)(1)(A):

> The governing body of a community mental health center shall:
>
> (i) be composed, when practicable, of individuals who reside in the center's catchment area and who, as a group, represent the residents of that area taking into consideration their employment, age, sex, and place of residence, and other demographic characteristics of the area, . . . (NIMH, 1978, p. v).

Need for the Study

While much has been written on the ideological mandate for citizen participation in all forms of social and community services, little information is found in the literature that quantitatively measures the outcomes. One is left with the feeling that inquiry into this issue in a more systematic way may be akin to heresy; but, nevertheless, the need is present to try to investigate methodically the effectiveness of citizen participation.

The importance of evaluating the effectiveness of citizen participation is underscored by Hunt (1973b):

> . . . in order for citizen groups to function effectively over the long haul, it is important to evaluate their activity and their effect on the planning and delivery of health services. Without adequate evaluative research, it will be impossible to know whether the experiment has been a success or whether changes are necessary to produce a more positive outcome (p. 31).

Any community mental health program that does not develop an effective mechanism for insuring adequate community involvement so as to relate itself to community needs will soon suffer from a lack of community support, often with financial or political consequences.

Statement of Purpose

The purpose of this study was to expand upon the research of Au Yeung (1973) and the Health Policy Advisory Center (Health PAC) of New York's study, "The Evaluation of Community Involvement in Community Mental Health Centers" (1972). In conjunction with this study, entitled Citizen Participation in a Community Mental Health Center, Au Yeung developed two scales, "Participants' Views of Citizen Participation in a CMHC" and "Participants' Perceived Influence on the CMHC," with 10 and five items, respectively. No reliability or validity data are reported for these scales. Further research in the area of refined measurement of the variables related to citizen participation is a logical next step and was the focus of

this study. A case study approach was used by Health PAC in surveying citizen participation in six community mental health centers in various parts of the United States. This study, while complete as descriptive research, made no effort to measure any of the variables or the effectiveness of the process of citizen participation in CMHC boards. As noted above, this has been the case in the field of citizen participation, which is usually described in ideological terms with little quantifiable data to support the concept.

Health PAC defines community involvement as participation in policy-making by direct service consumers, mental health professionals, and other community members, i.e., providers and non-providers of mental health services. Mechanisms of community involvement include boards or advisory groups, volunteers working in community mental health programs, employment of catchment area residents (mostly para-professionals in designated poverty areas), patient committees and advocates, and consultation and education services. The purposes of these mechanisms of community involvement are:

1. To educate and inform the community (direct service consumer group) about center services and how to use them.

2. To educate and inform center staff and administration about the perception of community needs, in particular mental health needs.

3. To engage the community as much as possible in the center's planning (operation) and evaluation.

It was also suggested in this study that community involvement contributes to the general level of mental health in the community through citizen participation in the self-determination of this community institution.

In summary, the purpose of this study was to develop an instrument to measure the variable: attitude toward citizen participation in CMHC boards.

Questions to be Addressed by This Study

The mechanism of community involvement that was of interest in this study was the CMHC board. Much controversy has revolved around the issue of the community mental health center's board and its role with respect to the program. This controversy gave rise to many research questions. Should a board be simply informed of decisions made by the staff after they are made or should the board have a policy-making role with substantial fiscal and programmatic authority? What is the impact of the level of participation on the effectiveness of the CMHC board as a mechanism of community involvement? What are the attitudes toward a particular model of decision-making or influence over the decision-making process? What is the role and function of citizen participation in community mental health? How should members be selected and by

whom appointed? How should the nature of representation be determined? What is the need for citizen participation? What are the characteristics of effective citizen participants?

The independent variables of the Health PAC study were the activity levels of community involvement as reflected in the quantity and quality of participation. The quantity of participation includes such considerations as number of participants, frequency of meetings, and amount of time spent; the quality of involvement dealt with representativeness, depth of participation, and the accuracy with which the mental health needs of the community are reflected. A second possible independent variable of interest is the attitude toward citizen participation.

The Health PAC study (1972) indicated that the effectiveness of the CMHC Board may be seen in terms of increased communication and understanding between the center's staff and community members. It suggested that there was a concurrence on service mission and that there was a positive correlation between community perception of need and the center's staff judgment. Other matters raised in conjunction with assessing the effectiveness of mechanisms for community involvement included resolution of conflicts, accountability across the staff-community boundary, communication of expectations, definitive roles,

and the general viability of the program in terms of community support.

Definition of Terms

A common understanding of the key terms used in this study is provided by the following definitions:

1. Community Mental Health Center (CMHC). In keeping with PL 94-63 of 1975, a Federally-funded CMHC consists of 12 services: inpatient, outpatient, day treatment, emergency service, consultation and education, transitional services, court screening, follow-up for state hospital patients, children's services, services for the elderly, and alcohol and drug abuse services. Each center serves a catchment area of 75,000 to 200,000 population and must have a governing/advisory board that is representative of the area served.

2. CMHC Board. The policy-making body of a community mental health center which must be composed of citizens who are representative of the catchment area. This group may be a governing or advisory board. The governing board provides the stronger form of citizen participation.

3. Consumer Board Members. Individuals who have actually used or have the potential to use the services of the community mental health center and can represent consumer interests. Also included are those who are members of the immediate family of the consumers.

4. Provider Board Members. Individuals who earn their living from the delivery of health care services including mental health services. Specific professions would include psychiatry, psychology, social work, and nursing.

5. Citizen Participation. A process whereby service users (actual and potential consumers), service providers, and at-large community representatives (community leaders) are involved in the policy-making aspects of the CMHC.

6. Community Leaders. Board members who are key business, professional, and elected community leaders who regularly serve on community boards and are active in civic affairs, and represent the middle class and more affluent members of the community.

7. Community Control. A process whereby representatives of mostly low income and ethnic/racial minorities attain representation and eventually policy-making control over the CMHC. This has been achieved after much controversy that has often had an ultimately destructive effect on the program.

Summary

In order to achieve any of the evaluation tasks on the effectiveness of citizen participation in CMHC boards mentioned above, it was necessary to be able to measure and quantify the independent and dependent

variables of interest. The purpose of this study was to develop an instrument to measure the variable: attitude toward citizen participation in CMHC boards.

Ultimately, it was expected that through the development of this scale, a means will be found to measure one of the major constructs in a field that abounds with ideological fervor but has little in the way of documentation and quantification. Through the development of this instrument, more information and knowledge will be acquired regarding the area of citizen participation, a process which is far from adequately understood. The need to study this area was evident as a community mental health center that does not develop a suitable mechanism for insuring adequate community involvement and citizen participation, so as to be responsive to community needs, will soon be suffering from a lack of community support, often with financial and political consequences.

CHAPTER II

THEORY AND SUPPORTIVE RESEARCH

Introductory Statement

In accord with the purpose of this study, which is to develop an instrument to measure the attitude toward citizen participation in CMHC boards, four areas of relevant research literature were surveyed. These were the history of mental health care, the ideology of citizen participation, citizen participation in CMHC boards, and attitude measures of citizen participation.

History of Mental Health Care

A familiarity with the ideology associated with mental health and illness was important to understand the development of mental health care. However, before one could discuss community mental health, the most recent mental health ideology to come into focus on the American scene, it was necessary to trace briefly the history of American psychiatry over the last 200 years.

A frame of reference was suggested for this by Golann and Eisdorfer (1972) who, in assessing the changes in the field, noted the universality of three related social-clinical processes:

1. Classification. Some acts or behavior patterns are distinguished from others and certain concepts may be grouped together under a single term such as neurosis.

2. Explanation. A belief system or theory is developed to account for the occurrence of certain acts of patterns of action.

3. Intervention or Regulation. A system of institutions, persons, or practices is built and sanctioned to cope with certain acts of behavior. For each phase of mental health ideology, there has existed a system of classification or preferred theory of causation and a sanctioned form of response (Golann & Eisdorfer, 1972, p. 3).

Two volumes (Zilboorg, 1941; Deutsch, 1949) surveyed in great detail the history of mental health care from the era of primative medical psychology through the period of the Greeks and Romans to colonial America. The following is a brief summary and review of the history which fits into the present system of mental health care. A central theme that runs through all modern mental health care is that of concern for the welfare of the individual and the preservation and enhancement of such institutions as the family, community, and society in general.

Prior to the emergence of humanitarian care, the mentally ill or disordered were considered holy or possessed by demons. Many cultures invoked gods or demons to explain behavior, while care in the form of exorcism of the mentally ill was expected from a medicine man or religious figure of the culture. Various forms of exorcism have been described throughout history, ranging

in degree and severity, and based upon a theory of how the evil may have entered the body of the afflicted. Examples of this include such procedures as trepanation, or boring a hole in the skull of the possessed individual to allow evil spirits to leave and good spirits to enter, thereby reducing or replacing the cause of the mental symptoms (Freedman, Kaplan & Saddock, 1975, p. 10), and the burning of witches at the stake as the "ultimate" cure in 17th Century Salem, Massachusetts for the suffering of disordered thought and behavior (Freedman, Kaplan and Saddock, 1975, p. 46). Less severe but equally dramatic were the reports of Shamanism, or the inspirational activities of the tribal medicine men. "Frequently, the patient's liberation from the evil spirit was expressed concretely through the explusion of an object such as a stone, insect or from the mouth of the Shaman" (Freedman, Kaplan & Saddock, 1975, p. 11). Vincenzo Chiarugi in Italy, William Tuke in England, Phillippe Pinel in France, and Benjamin Rush in America are generally credited with the curbing of harsh and objectionable practices with respect to the care of the mentally ill. Pinel is best known for his liberation of the mentally ill at Salpetriere in 1795. The work of these men led to the development of the concept of moral treatment in the early 1800s.

Ruth B. Caplan (1969) discussed moral treatment and the concepts which provided its philosophical and scientific base.

> The essence of moral treatment was the belief that because of the great malleability of the brain surface, because of its susceptibility to environmental stimuli, pathological conditions could be erased or modified by corrective experience. Therefore, insanity, whether the result of direct or indirect injury or disease or of overwrought emotions or strained intellectual faculties, would be cured in almost every case (Caplan, R. B., 1969, p. 9).

The mentally ill were, therefore, seen as sick rather than guilty of an act which was deserving of punishment. They were to be treated like those suffering from physical illnesses rather than locked in poorhouses or jails.

Physicians who were involved in moral treatment were personally involved in the care of their patients in small institutions where caring, hopeful attendants provided kind and respectful treatment. Dorothea Dix became concerned that this type of treatment was not available to the majority of those who needed it but only to the mentally ill of the more affluent families. By petitioning state legislatures throughout the United States, she is credited with the founding or enlarging of more than 30 state hospitals during the period of 1840 to 1880. It was this expansion of services, coupled with immigration in the latter part of the 1880s and the consequent increase of poor "foreigners" attempting to adjust to the American way of life, that caused increased numbers of

patients to be admitted to the state hospitals, thereby causing an overload upon available resources which, consequently, brought a decline in the quality of care which led to a prevalent custodial ideology. Grob (1966) indicated that other factors contributed to the decline of care in state institutions, such as the professionalization of psychiatry and the increased reliance upon psychiatry as a scientific discipline based on a somatic model of treatment. At the same time that psychiatrists were becoming more scientifically oriented by virtue of their identification with and training in medicine, they were having a harder time being associated with mainstream "acute care" medicine of the general hospital. The large state institution located in a rural environment with minimal hospital facilities contributed to this. Mechanic (1969) concluded that

> the trend toward professionalization isolated psychiatrists from the more humanitarian and compassionate ideologies existing in the society and replaced these with a barren, alleged objectivity which offered little help or hope (Mechanic, 1969, p. 54).

The emphasis on humanitarian care and its decline, often referred to as the first revolution in psychiatry (Goldenberg, 1973, p. 295), led to the second revolution, which directed attention to the inner psychological life of man emphasizing developmental stages and the role of the unconscious. Concerns in classification changed from categorization of symptoms to elaboration of mechanisms

of defense. Golann and Eisdorfer (1972) discussed problems with the psychoanalytic approach:

> The variations on the psychoanalytic theme proliferated but all shared the difficulty that patients were those who could afford such treatment and had the verbal capacity and adaptability to deal with a variety of feelings and memories not usually at the level of awareness of the patient when he requests help; this, of course, leads to a variety of alternative styles of verbal interaction with patients but effective psychotherapy was not available to large numbers of individuals because of financial or logistical constraints, unfamiliarity of socially advantaged mental health professionals with practical living problems faced by disadvantaged clients and the impracticality for disadvantaged clients of a method requiring long periods of retrospective analysis (Golann & Eisdorfer, 1972, p. 6).

Prior to World War II, 3000 psychiatrists practiced in the United States. The outbreak of war brought about a concern for conducting an appropriate psychiatric medical screening of all those inducted into the military. A proposal from the profession of psychiatry to screen all inductees was implemented but failed in effectiveness due to the limitations in manpower. Large numbers of American males were rejected from military services for psychiatric reasons. This experience, as well as the experience of mental health professionals in the war zone, once again pointed to the need for stronger public mental health programs of prevention, as well as treatment.

Following the war, concern for the mental health needs of the country was reflected in the high rejection rate of selective services, as well as the need to care

for those in the Veterans' Administration system who had been disabled in the war. This provided the impetus for Congress to pass the Mental Health Act of 1946 which led to the establishment of the National Institute of Mental Health (NIMH) in 1949. The intent of this program was to combine a public health approach with mental health. The NIMH budgets reflect the increased involvement of the Federal government in mental health from 1950 with a budget of less than $9,000,000 to $68,000,000 in 1960, $338,000,000 in 1967 (Mechanic, 1969, p. 57), and $503,000,000 in 1978.

In 1955 the Mental Health Study Act authorized the Joint Commission on Mental Illness and Health to conduct

> an objective, thorough and nationwide analysis and evaluation of the human and economic problems of mental illness and of the resources, methods and practices currently utilized in diagnosing, treating and caring for and rehabilitation of the mentally ill, both within and outside institutions as may lead to the development of comprehensive and realistic recommendations for such better utilization of those resources (PL 84-182 as reproduced in Joint Commission on Mental Illness and Health, 1961, p. 303).

In 1961 the Joint Commission published its report entitled Action for Mental Health, which called for

1. A tripling of mental health expenditures in ten years.

2. A new and better recruitment and training program for mental health professionals.

3. Expansion of treatment programs for acutely ill patients in all facilities, including community mental health centers, general hospitals and mental hospitals.

4. Establishment of one mental health center for every 50,000 persons in the population.

5. Conversion of large state hospitals to smaller regional intensive treatment centers with no more than 1,000 beds.

6. New programs for chronic patients such as aftercare and rehabilitation services (Mechanic, 1969, p. 60).

The following year a cabinet-level committee reviewed the Joint Commission's recommendations and, on February 5, 1963, President Kennedy sent to Congress his message on Mental Illness and Mental Retardation. The President called for "governments at every level--Federal, State and Local, private foundations and individual citizens [to] face up to their responsibilities in this area" (Kennedy, 1963). A bold new approach was needed "to use Federal resources to stimulate State, Local and private action" (Kennedy, 1963). The President's message also cited the need for broadly conceived community mental health centers, rather than clinics, that would work toward the elimination of state hospitals. Federal programs for the construction and staffing of community mental health centers, which were to include the five essential services of inpatient, outpatient, partial hospitalization, emergency services, and consultation and education, followed. The overall goal of the community

mental health centers program was the establishment of 2000 centers. As of April, 1978, the total number of centers funded was 649 and future growth was uncertain. The emphasis in the CMHC's upon early diagnosis and prevention, based upon understanding of social and community factors, has been referred to as the "third revolution" in mental health, or the community mental health movement.

Gerald Caplan (1969) reflected on the history of American psychiatry and states,

> I now realize that traditional American psychiatry has been community and population-oriented from its beginning and that, with all its undeniable assets, the individual patient orientation of academic and psychoanalytic psychiatrists of the last twenty to thirty years has been to some extent a withdrawal to a professionally controlled haven from the difficulties of grappling with the demands made upon us by the society that sponsors our operations. Community psychiatry is not merely a bright new idea developed by some of us in the 1960s as a reaction to our awareness of the shortcomings of the individual approach but is a return to an orientation that was our basic mandate from society when our profession was established and within the framework of which it has been developed (Caplan, G., 1969, p. 320).

Caplan continued by discussing the importance of confrontation between psychiatrist and the public:

> If we organize or participate in programs that are administered or financed by public bodies, particularly state or local governments, we must be prepared to accept the political framework within which support is given (Caplan, G., 1969, p. 322).

He outlined five principal purposes to be served by this interaction:

1. To communicate with legislators or others who distribute community resources . . . in order to persuade them to allot to us an appropriate share of such resources in competition with representatives of other groups and resources.

2. To influence social policy planning.

3. To monitor salient need to which mental health services should be addressed and to find out how to utilize non-psychiatric resources in the community to extend the impact of mental health professionals.

4. To elicit feedback from the recipient population to those providing the mental health services.

5. To obtain sanction for our activities (Caplan, G., 1969, pp. 340-344).

Finally, Caplan commented that the most important aspect of the professional-public confrontation was "the ever present danger of retiring into our own professional group and reducing or interrupting communication with the public and its leaders when they criticize or attack us or when they say things we do not like to hear" (Caplan, 1969, p. 345).

The Ideology of Citizen Participation

Citizen participation has been a much written about topic. The idea of citizen participation has taken on ideological proportions as a result of its roots in American history, as well as the resurgence of community involvement during the mid-1960s in the community action programs associated with the "War on Poverty." Spiegel

and Mittenthal (1968) in their bibliographic review of the citizen's participation literature entitled, "The Many Faces of Citizen Participation" cited several reasons for the elusive nature of the concept. They stated that although there is some information available on the topic, there is not enough to be able to draw reasonable conclusions. An additional factor that clouded the situation was bias:

> . . . A scientific approach to citizen participation is extraordinarily difficult, suffused as it is with nominative judgment, value laden preconceptions, lack of objective criteria and standards of measurement, and a host of differentiated perspectives from which anyone can draw just about whatever meanings his predilections desire (Spiegel & Mittenthal, 1968, p. 4).

Given the above cautions, an attempt will be made in the following pages to sort through the citizen participation literature first as it relates to the general concept and then to the specific areas of community mental health. John Rehfuss, in his book Public Administration as a Political Process, indicated that

> the program dealing with Community Action Programs (CAP) was unusual in that it attempted to alleviate poverty by directly involving the poor in designing and operating programs for their own benefit. To the extent that it attempted to make poor and powerless persons a separate political force operating at the local level, it was a revolutionary idea designed to federally finance opposition to local political leaders in city hall (Rehfuss, 1973, p. 14).

"Maximum feasible participation" was the language of the "War on Poverty." By this, it was expected that

the poor of communities, both urban and rural, across the United States would become involved in the governance of programs that affected their everyday lives. Sargent Shriver (1965) justified the requirement for maximum feasible participation of the poor by stating

> It is desirable for the same reason that a business concern tries to find what the consumer thinks of his product. You would not be in business twenty minutes if you did not run consumer surveys. . . . We are trying to find out what the poor people really think about what all the rest of us are doing theoretically for their benefit (Shriver, 1965, p. 1).

Shriver's suggestion was well taken, given the "non-market" aspect of many community programs. The non-market aspect of a program represents a basic difference which must be reckoned with by designing alternative mechanisms of ascertaining the satisfaction or non-satisfaction of the consumers of that service.

Kramer (1969), in his article entitled "Prelude: Four Modes of Resident Participation," described the Community Action Programs that developed out of the Economic Opportunity Act of 1964. Because this legislation was written in the same period as the Community Mental Health Center legislation, the commonality of the two documents with respect to citizen input is apparent. The four modes of participation were as follows:

1. CAP Policy-Making. The poor were cast in the role of policy-makers as voting members of the governing board of directors. In this capacity, the representatives of the

poor were regarded by OEO as essential members of a tripartite coalition, along with the major governmental and voluntary welfare agencies, and the leadership of important elements in the community such as labor, business, religious and minority groups (Kramer, 1969, p. 6).

2. Program Development. Resident participation took place on the neighborhood level and was linked to the first through elected representatives to the CAP's board of directors from the target area. The core process was one of program development; here the poor were initially received primarily as consumers who could give useful advice and suggestions to those responsible for the planning and delivery of social services (Kramer, 1969, p. 11).

3. Social Action. The third type of resident participation was the most radical and controversial of all and for many persons the possibility of increasing the power of the poor was either the most objectionable or the most encouraging feature of the CAP (Kramer, 1969, p. 13).

4. Employment. The fourth and perhaps the least controversial way in which the poor could participate was through employment as aides or in other non-professional roles, some of which were defined as "new careers" in educational, health, welfare, legal and correctional agencies. Employment was originally regarded as the primary, perhaps sole form of resident participation (Kramer, 1969, p. 18).

Lane (1962) pointed out that political participation is not the central mode of need satisfaction for most Americans. Political scientists such as Milbrath (1965) have been interested in the degree of intensity of the participation and define participation in politics in terms of apathetics who are not active in the political process, spectators who view it as a spectator sport, and

finally, gladiators who maintain a high level of involvement in political activities. Milbrath concluded that most Americans play a passive role in relation to participation in party politics. Hofstetter (1972) defined participation as "the conscious involvement of people in the collective pursuit of a goal" (Hofstetter, 1972, p. 225). He also stated that those who are more politically active feel more politically effective, have a higher sense of obligation to participate, are less alienated from politics, manifest less hostility, are less misanthropic, have greater ego strength, and show more partisanship than those who are apathetic. These qualities increase as they become more active and upon close examination seem to be closely related to at least a limited definition of improved mental health. In addition, those who are most politically active maintain democratic values of tolerance, public responsibility, and adherence to the rules of the game more than the less active do. This has been emphasized in the citizen participation literature as a particularly important feature of involving citizens in the governance of community institutions.

Milbrath discussed the decisions of an individual to act in a particular way with respect to a political issue as "a function of the interaction between the particular pattern of predisposition possessed by the

organism at a given point in time" (Milbrath, 1965, p. 73). Predisposition can be categorized into:

(a) Physiological and psychological needs.

(b) Beliefs.

(c) Attitudes.

Beliefs and attitudes can be viewed as a function of a learning mechanism called reinforcement. Political attitudes are cognitions about and positive or negative feelings toward political objects. These political objects can be broadened to encompass attitudes toward a mental health agency and the predisposition to become involved in the decision-making process of such an organization. Measuring the attitude of an individual (board members, mental health staff, community agency representative, consumers) toward citizen involvement in the decision-making process of a mental health agency may be seen as a predictor of how that individual will behave with respect to the attitude object (citizen participation ideology).

Lane (1962) stated that any ideology supports or weakens the institution of democracy. The concept of citizen participation in mental health services has taken on the proportion of an ideology and may be characterized according to Lane's concept of an "ideology." Lane stated that the term "political ideology" means a body of concepts with the following characteristics:

1. They deal with the questions: Who will be the rulers? How will the rulers be selected? By what principles will they govern?

2. They constitute an agreement that is intended to persuade and to counter opposing views.

3. They integrally affect some of the major values of life.

4. They embrace a program of defense or reform or abolition of important social institutions.

5. They are, in part, rationalizations of group interests but not necessarily the interest of all the group espousing them.

6. They are normative, ethical, moral in tone and content.

7. They are (inevitably) torn from their context in a broader belief system and share structural and stylistic properties of that system (Lane, 1962, p. 14).

Most ideologies have these qualities:

1. They are a group of beliefs that individuals borrow; most people acquire an ideology by identifying (or disidentifying) with a social group.

2. They have a body of sacred documents (constitutions, bills of rights, manifestos, declarations) and heroes (founding fathers, seers and sages, originators and great interpreters (Lane, 1962, p. 15).

All ideologies, like all other beliefs, imply an empirical theory of cause and effect in the world and a theory on the nature of man.

Democratic values heavily support participation in group decision-making. Gibb, Platts, and Miller (1951), in a study entitled Dynamics of Participative

Groups, enumerated the characteristics of a democratic society which supported participative action:

1. A belief in the dignity and worth of the human personality.

2. A belief in the equality of the rights and worth of all men.

3. The right of all men to participate in the decisions vital to the group.

4. A confidence in the capacity of man to work out his goals and solve his problems.

5. The availability of all knowledge or data relevant to the decision-making process (Gibb, Platts & Miller, 1951, p. 77).

Cahn and Cahn (1971), in reviewing the concept of masimum feasible participation associated with the Office of Economic Opportunity (OEO) community action programs of the late 1960s, listed the values of citizen participation which they believed fell into three broad categories:

1. A means of mobilizing unutilized resources, a source of productivity and labor not otherwise tapped.

2. A source of knowledge--both corrective and creative, a means of securing feedback regarding policy and programs and also a source of new incentive and innovative approaches.

3. An end in itself--an affirmation of democracy and the elimination of alienation and withdrawal, of destructiveness, hostility and lack of faith in relying on people (Cahn & Cahn, 1971).

Mogulof (1974) examined the different patterns and purposes of citizen participation in Federal programs,

and discussed the shifting view of citizen participation in Federal programs. The initial problem was defined as a need "to increase program effectiveness, to redistribute power, to build an effective political constituency for new programs . . . whereas, it is now a question of . . . group rights and power vis-a-vis the larger community" (Moguluf, 1974, p. 68). Federal policy in 1974 was still addressed to the older definitions of citizen participation with little agreement about what direction policy and practice would take. Mogulof, in demonstrating the lack of agreement as to the purpose of citizen participation, listed eight varied purposes which he researched in OEO publications:

1. Decentralizing governmental authority.
2. Engineering the consent of the governed.
3. Insuring equal protection to individuals and groups through a watchdog citizenry.
4. Curing alienation and other social diseases of our time by a form of therapy.
5. Employing residents so as to "humanize" service.
6. Creating cadres of antirioters.
7. Building a constituency for the program.
8. Redistributing power (Mogulof, 1974, p. 69).

Mogulof concluded that

> Citizen participation policy at the Federal level is erratic, piecemeal, misunderstood and possibly not really cared about. This patchwork of Federal attitudes and practices, however, may have had

> greater utility in contributing to Federal and local experimentation with regard to participation, in the decade of the 1960s . . . to continue the "benign anarchy" of citizen participation policy in the 1970s would be the denial of the utility of these experimental years (Mogulof, 1974, p. 76).

A recent publication by the Community Services Administration (1978) entitled Citizen Participation reflected an effort on the part of the Federal government to respond to why the citizen participation requirements vary from program to program. The authors took the view that there is a rationale for the varied citizen participation requirements in Federal programs "because the programs are different and the goal of citizen participation is significantly different from program to program and because the general philosophy reflected in legislation and policy has changed over a period of time" (Community Services Administration, 1978, p. 13). In fact, this publication was primarily devoted to summarizing citizen participation requirements in programs as varied as the Departments of Agriculture, Commerce, Justice, and Health, Education and Welfare.

Warner (1965), in his discussion of the problems of participation, indicated that to succeed organizations must have membership participation. Yet, getting the quality and quantity of participation they want turned out to be one of their most difficult and persistent

problems. Participation is a problem for several different reasons:

1. Participation is essential to some degree but rates of participation tend to be low.
2. Participation is seen as a symbol of organizational success.
3. Society places value on democratic participation with the concurrent idea that low participation threatens the democratic operation of the organization (Warner, 1965, p. 128).

Warner divides the factors that influence participation into three categories:

1. The attributes of the participants.
2. The environments, both physical and social.
3. The organization itself, its structure and procedures (Warner, 1965, p. 130).

Of interest to this study were the attributes of the participants, which included such variables as age, sex, marital status, educational level, occupational status, and income. More difficult variables reflective of participant characteristics were motivation, attitudes, beliefs, values, health, etc. The area of participant attitudes was the focus in this study.

Citizen Participation in CMHC's

Much work has been done to understand the issue of citizen participation in the CMHC services. The issue has frequently become that of citizen participation versus

consumer control. Roman and Schmais (1972) pointed out that:

> The dominant characteristic of citizen participation in the health and welfare fields, until the advent of federally sponsored programs emphasizing involvement of the poor, has been middle and upper middle-class membership on advisory boards, health councils, trustee committees and governing committees (Roman & Schmais, 1972), p. 67).

Only recently has traditional board composition and board member role been questioned with respect to representativeness, selection and appointment of membership and participant characteristics ultimately leading to questions of which interest controls the decision-making process. Holton, New and Hessler (1973) describe three models for citizen involvement in CHMC's. A study done at Tufts University concluded that the CMHC's surveyed defined citizen involvement in the traditional middle-class pattern of housewives, businessmen, lawyers, and ministers whose main role was to raise funds and not raise serious questions about the professional directions of the agency. This is the model of the elitist board. The second is an advisory model with a majority of low-income and minority group consumers and community residents as representatives. This model has largely been rejected in poverty area CMHC's, in lieu of governing board functions, where playing an advisory role is seen as a symbol of the general powerlessness of the community. The third model is that of consumer control in which a

governing board is composed of a cross-section of catchment area residents and, in its purest form, is set up as a community corporation to administer the CMHC. This model seems to be relevant particularly in poverty areas where there is a potential conflict between the perception of mental health needs by middle-class mental health professionals and residents of the area. The board, it is hoped, serves as an effective mechanism for mediating perceptions, indentifying needs, and developing a program which is relevant to all parts of the catchment area, including the low-income, disadvantaged, and minority group community residents. If this is accomplished, community support for the program is the outcome.

Kupst, Reidda, and McGee (1975) studied 18 community-based community mental health centers in urban settings, attempting to compare their developments, functions and powers. Four groups were surveyed:

1. Citizen board members.
2. Board chairpersons.
3. Center staff.
4. Center directors.

The groups generally agreed that the primary function of a Community Mental Health Center Board was to see that needs were met. Other functions considered were program and policy advice, keeping the center visible, and direct involvement of the community in assessing needs. With

respect to degree of involvement, board members saw their role as advisory, staff favored co-decision or advisory, directors favored co-decision, and chairpersons wanted more board control. There were differing perceptions between staff and board members regarding reasons for joining boards, with staff feeling that joining was related to a need for prestige and status and board members to a desire to serve the community.

McGee and Wexler (1972), in discussing the political considerations of community-based mental health services, indicated that "mental health professionals must recognize the importance of local political figures in the development of . . . programs in an urban area and move toward a spirit of openness and cooperation" (McGee & Wexler, 1972, p. 303). They stated that

> it is sobering to recognize that political figures may listen more carefully to community residents than to mental health professionals. . . . The mental health professionals frequently come from outside the community. . . . Community residents come from the community and represent votes (McGee & Wexler, 1972, p. 308).

The political and professional considerations cannot be separated in the development of community mental health programs. McGee and Wexler point out the necessity for strong working relationships between professional and community residents, citing three tasks for community residents:

1. To work closely with local political representatives to keep them informed of the mental health needs in their community.

2. To provide increased awareness to both political representatives and health officials.

3. To act as advisors and evaluators in relation to such things as plans, availability and effectiveness of community-based services in an urban setting (McGee & Wexler, 1972, p. 309).

Kenny and Ehrenreich (1974) assembled a particularly detailed description of the situation in 1968 which led to a confrontation between Columbia University and the New York City Community Mental Health Board (CMHB) and the Washington Heights Community.

> The Washington Heights controversy may have made more of an impact on CMHB and Columbia than they were willing to admit. The recognition that there was, somewhere out there, a "community" . . . structured, vocal, and capable of raising the same kind of community . . . control demands that were paralyzing the New York City school system at that time caused a profound rethinking of community mental health by both CMHB and Columbia. For both, the Washington Heights confrontation has been their first sustained encounter with any kind of organized consumer constituency (Kenny & Ehrenriech, 1974, p. 168).

The authors pointed out that it is their feeling that frontal attacks on establishment institutions such as Columbia University will be the major weakness of the community mental health movement. No group actually wins or loses and, in support of this, the authors point out that in Washington Heights "the symbolic victory of the

control has yet to be translated into tangible services" (Kenny & Ehrenreich, 1974, p. 170).

Dudley (1975) described a more orderly process for involving citizen participants in CMHC programs in a large urban area. While the State of Pennsylvania, in its Mental Health/Mental Retardation Act of 1966, only allowed for a 13-member advisory board at the county level, the City of Philadelphia developed a set of regulations for citizen participation which the author proposed "may serve as a model for the other county mental health/mental retardation offices that are developed or intending to develop community participation regulations" (Dudley, 1975, p. 417).

The history of community control has been a mixed one emanating from the early 1960s and the experience of several Federal programs in housing, poverty, and health. Moynihan (1969) discussed the apparent contradiction of community control.

> Complete community control usually meaning black control of all community affecting institutions becomes the demand of more militant whites. On the surface, a reasonable enough position, in reality, took the form of denying the legitimacy of those institutions of electoral representation that had developed over the years--indeed, the centuries--and which normally did provide community control. Plebiscitory democracy; the people-in-council became the seeming non-negotiable demand of many . . . . This quickly enough becomes government . . . by process of private nullification which has never been especially good news for democracy. It would

> be absurd to blame the community action programs for the legitimization of something called "community control" in opposition to the established system of electoral representation. The assumption that established systems were not meeting the needs of people was certainly much encouraged by the community action movement (Moynihan, 1969, p. 78).

Weissman's discussion of community control (1970) provided further clarification of Moynihan's point:

> Much of the rhetoric of those who advocate community control is strikingly similar to the rhetoric of what has been described . . . as the ideal "community organization process." This process is essentially a rational problem solving process in which there is complete and open sharing of all information and facts, full discussion and ultimate decision-making on the part of everyone in the community. Indeed this process is the ideal democratic procedure taught in any high school civics course (Weissman, 1970), p. 168).

Hersch (1972) pointed out additional problems with community control, such as the emergence of local leaders who are not representative of the community, power on the community board not necessarily wielded for the sake of rational program development, and the intense anger that can be directed at professionals which has an "anticolonialist" quality about it. Hersch believed the problems are not limited to low-income boards but are more pronounced when they do occur. He encouraged mental health professionals not to romanticize working in these settings but to examine all aspects of the situation which would lead to a realistic sharing of power between professionals and community residents.

Others, such as Meyers, Dorwart, Hutcheson and Decker (1974), have conceptualized the problem of citizen participation in terms which are broader than the issue of community control or representativeness. In their study, board accomplishment was seen as the central concern with a concomitant interest in being able to quantify how well boards achieve their goals and objectives. Four separate types of accomplishments were identified:

1. Service creation or improvements.
2. Mobilization of outside resources.
3. Local autonomy.
4. Coordination (Meyers, Grisell, Gollin, Papernow, Hutcheson & Serlin, 1972, p. 319).

These four typologies are considered to be independent of one another and "represent four very different strategies that an area board can follow in pursuing its goals and legislative mandate. This information should prove valuable to area boards in more clearly defining their roles and in planning future activities" (Meyers et al., 1972, p. 320).

Another strategy cited in the literature for the purpose of lending order to the CMHC planning process was described by Krauss and Phillips (1974). This article described the work of two architects who developed a planning aid kit (PAK) to facilitate the community-based design of CMHC services. Included in the PAK are guidelines for planning group composition to include mental health professionals and paraprofessionals and

representatives of the catchment area to be served. The planning process is structured around ten meetings and ten workshops in which mental health services and facilities are designed, using an environmental design approach based on understanding how a proposed environment is to be used before detailing its physical appearance. This technique, while supportive of an orderly planning process for CMHC programs, seems to lend itself best to communities that are not involved in a destructive form of controversy over who will ultimately control community mental health services.

Bertelson and Harris (1973) reviewed the accomplishments of the District V CMHC in San Francisco, California, in their organizing efforts with the citizens of the catchment area. The strengths and weaknesses of the process were reviewed in this article which essentially described the community organization process for the CMHC in the context of a predominantly middle-class neighborhood. This study identified the most salient contribution that can be expected from citizen participation as follows:

> Board members gain familiarity with and confidence in the CMHC philosophy, but they also retain a critical viewpoint. They ask challenging questions such as: Do institutions return patients to the community too quickly, and does the portion of time allotted to consultation pay off? (Bertelson & Harris, 1973, p. 556).

Rabiner (1972) described the initial stages of the organization of a community advisory committee in a department of psychiatry that had applied for a Federal CMHC staffing grant. The unusual feature of this particular process seemed to be the real commitment of the department of psychiatry to involve lay representatives in the delivery of mental health services. This article cited an excellent example of coalition building (community and department members traveling to Washington to support the grant application) that is possible when power is shared. Unfortunately, the article ended abruptly with a discussion of how heavily involved the community would be in the financial management of the center because the article was written just prior to the award of a Federal grant of two million dollars. The position was taken, however, that training for CMHC board members would make a significant difference in their ability to play a meaningful and active role:

> Rather than assume that our board members are unable to become involved in the center's finances, we take the position that they require training in finance and management. Certainly their commitment to the mental health center has been well documented. In our opinion, business knowledge can be supplied to them more readily than a commitment to the community can be supplied to some who, although well versed in business affairs, lives in another world (Rabiner, 1972, p. 121).

Golann and Eisdorfer (1972) indicated that

> the major issue of the 1960's has been the achievement of increased flexibility and comprehensiveness of mental health services. The major issue of the 1970's will be that of community control over the mental health field, a process to date that has been initiated largely by professionals and taken over by the urban poor (Golann & Eisdorfer, 1972, p. 14).

Attitude Measures of Citizen Participation

A search of the literature (Shaw & Wright, 1967; Comrey, Baker & Glaser, 1973; Bonjean, Hill & McLemore, 1967; Miller, 1970; Chun, Cobb & French, 1975; Lake, Miles & Earle, 1973; Robinson & Shaver, 1969) with respect to attitude measures revealed that there are no scales available that purport to measure the attitude toward citizen participation on CMHC boards.

Robinson, Rusk and Head (1968) reported a collection of scales relating to liberalism and conservatism of political attitudes, community-based political attitudes, and political participation. All of these scales deal with broad political issues rather than the political process inherent in a CMHC board.

Scales in Au Yeung (1973) entitled "Participants' Views of Citizen Participation in a CMHC" and "Participants' Perceived Influence on the CMHC" report no reliability or validity data for the 10- and five-item scales,

respectively. Both scales were constructed in the (Likert) summated rating format.

Other related scales, such as the Baker-Schulberg Community Mental Health Ideology Scale (Baker & Schulberg, 1967) and the Gottesfeld Community Mental Health Critical Issues Test (Gottesfeld, 1972), contain individual items of general relevance to citizen participation in community mental health, but only as they relate to community mental health as an overall concept. Other studies reviewed, such as Decker (1974), examined the roles of citizen participation in Massachusetts Mental Health Advisory Councils but do not report attitudinal ratings or make any attempt to construct an instrument other than a survey-type questionnaire.

From this point in the literature, efforts at developing measures of citizen participation in community mental health services become more diffuse; the literature shifts back to a descriptive and ideological approach.

Based upon the inadequacy of the scales cited above, that is a broad rather than specific focus on citizen participation, the most minimal psychometric data and finally what amounted to an intuitive approach to attitude measurement, it was decided to explore in depth through a systematic empirical effort the question of attitude toward citizen participation in a CMHC board.

In spite of the inadequacies, some effort was made to incorporate some items in the scale for this study.

The technique of scale construction known as the method of summated ratings is drawn from the work of Likert (1932) in which, as part of a larger investigation begun in 1929 by Gardner Murphy, a different method of attitude scaling was developed which represented a radical departure from the work of Thurstone and the method of equal-appearing intervals. Likert asked if it was possible to construct equally reliable attitudinal measures by using simpler scaling techniques that did not involve the laborious procedures of having judges sort items into categories. Likert also felt that a simpler scale perhaps did not have to make "unnecessary assumptions" (Likert, 1932, p. 35). He was careful to point out that he was raising these questions in the spirit of academic inquiry.

> It is feared that someone will mistakenly interpret this article as an attack on Thurston's methods. I, therefore, wish to emphasize in the strongest terms that I am simply endeavoring to call attention to certain problems of method and that I am very far from convinced that the present data closes the question (Likert, 1932, p. 6).

Likert defined an attitude as "a tendency toward a particular response in a particular situation" (Likert, 1932, p. 4).

Many varied definitions of attitude were found in the literature, which emphasized the cognitive,

affective, conative, or evaluative aspects of the construct. Other definitions of attitude are:

> An enduring learned predisposition to behave in a consistent way toward a given class of objects (English & English, 1958, p. 50).
>
> A mental state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related (Allport, 1954, p. 45).

Jordon (1971) pointed out that: "two basic views permeate the literature on attitude research: one defining attitude as a 'predisposition to behavior' and the second emphasizing attitude as 'behavior'" (Jordan, 1971, p. 8). A behavioral definition of attitude is provided by Guttman (1950) who defined attitude as the "delimited totality of behavior with respect to something" (Guttman, 1950, p. 48). Thurstone (1946) defined attitude in terms of feeling as "the degree of positive or negative affect associated with some psychological object" (Thurstone, 1946, p. 43).

The way in which an attitude is defined will naturally have a direct relationship to the way in which the attitudinal measurement is designed. For the purpose of this study, Shaw and Wright's (1967) definition of attitude was used:

> A set of affective reactions toward the attitude object, derived from concepts or beliefs that the individual has concerning the object, and predisposing the individual to behave in a certain manner toward the attitude object (Shaw & Wright, 1967, p. 13).

Likert made several recommendations in the selection of items for scale construction:

1. It is essential that all statements be statements of desired behavior and not statements of fact. Present rather than past behavior is measured in that way. The term "should" is a way of stating the proposition so that it involves desired behavior.

2. Each statement should be clear, concise and straight forward, using the simplest possible vocabulary. No double negatives should be used or other wording that would be confusing. Avoid every kind of ambiguity.

3. In general, it would seem desirable to have each statement so worded that the modal reaction to it is approximately in the middle of the possible responses.

4. About half the statements should give a "strongly approve" and half should be "strongly disapprove" distributed randomly throughout the attitude scale (Likert, 1932, pp. 44-46).

Likert, Roslow and Murphy (1934) indicated that the summated rating method of scoring, which does not involve the use of a judging group, was found to be "consistently more reliable than the original method of scoring. The scores obtained by the two methods correlate highly, indicating that they are measuring essentially the same thing" (Likert, Roslow & Murphy, 1934, p. 237).

Tittle and Hill (1967) conducted a study in which they used several well known methods of attitude scale construction and compared their abilities to predict voting behavior among college students. The Likert Scale was superior among the scale types, yielding a mean

correlation coefficient of .54 with the objective indices of voting behavior.

> The Likert Scale was found to be the best predictor and to exhibit greatest reliability, while the Thurstone Scale is the poorest predictor and the least reliable. The findings, with respect to the range of reliability, are similar to those reported in other studies using Likert's and Thurstone's procedures. In addition, the available evidence suggests that in cases where the two types of scales are of equal length one can expect the Likert Scale to exhibit higher reliability (Tittle & Hill, 1967, p. 211).

The second scaling technique used in this study was the semantic differential (Snider & Osgood, 1969). The semantic differential was used to obtain a concurrent measure of validity by using 19 pairs of bipolar adjectives describing citizen participation in CMHC boards to which the subject responded. Three factors were assessed with the semantic differential technique: an evaluative factor, a potency factor, and an action factor. Reliability has been reported by Osgood, Succi and Tannenbaum (1957) ranging from .83 to .91. Validity measures have been reported by correlating the semantic differential with the other scales, such as the Thurstone, with a range of .74 to .82 (Osgood et al., 1957).

Summary

This literature review has verified a number of ideas that are of significance for this study. Mental health care has evolved to its present level based on

commonly held assumptions as to the causes of mental illness. The literature review has traced this from a belief in evil spirits and deficit in moral character to the presently held theories of biopsychosocial causation of mental illness. Citizen participation in American government (participatory democracy) has had a long history but during the 1960s took on a particular ideological fervor when associated with local control of community services. The community mental health movement represented an intersection of these forces with specific applications being made to the boards of community mental health centers as a social experiment in the delivery of mental health care. The review of the literature indicated that much work had been done in tailoring mental health services to local needs. As the 1970s draw to a close, accountability and cost effectiveness of community mental health center programs has become a main concern. The effectiveness of citizen participation in CMHC boards has been cited as an area for study, but in order to do this an evaluation technology is required. The literature review has verified that there is little instrumentation available to measure the impact of citizen participation. The methodology chapter that follows describes an effort to develop instrumentation that should be useful for further evaluative studies of the impact of citizen participation in CMHC boards.

CHAPTER III

DESIGN AND METHODOLOGY

Introductory Statement

The purpose of this study was to develop an instrument to measure the variable: attitude toward citizen participation in Community Mental Health Center (CMHC) boards. This chapter will present the processes used in developing the scale from the original 80 items composed of statements found in the review of literature to its final 30-item version. The methods used to test the reliability and validity of the scale are described as part of the process of developing the instrument.

Procedure

A pool of items based on 80 declarative statements was developed based upon an extensive review of the literature of citizen participation in CMHC boards. Many of the statements were taken directly from articles and books reviewed reflecting an author's belief in a particular aspect of the citizen role.

Following the development of the pool of items it was postulated by the author that seven a priori factors

or subscales could be distinguished as comprising parts of the overall scale under development:

CDM - Control Over the Decision-Making Process: What different models of decision-making exist among CMHC boards? On a continuum, they range from full policy-making control to token or non-existent input. Which model reflects an appropriate degree of influence over the CMHC's decision-making process?

RCB - Role of CMHC Board: Should the role of the board be well defined? Does this help the members perform a more useful function? What are the appropriate functions of the board? How does the board decide what tasks it should perform?

SAM - Selection and Appointment of Members: How are board members selected? What is the appropriate means of selection? How should board members be appointed?

RB - Representativeness of Board: Who should be represented on the board? What should the scope of membership be in order to have a board which reflects the catchment area population? What should be the relative proportion of professionals, consumers, and community leaders represented on the board?

ICP - Impact of Citizen Participation: What effect does citizen participation have upon the community and the mental health program with which it is associated? Does citizen participation make a difference?

NCP - Need for Citizen Participation: Can relevant community mental health services be provided without citizen participation? Who says citizen participation is necessary?

PC - Participant Characteristics: How energetic and active should participants be who are members of CMHC boards? Are the best members those who are already active in other agency boards? How knowledgeable should participants be about mental health issues?

A review of the declarative statements indicated the following distribution based on the seven a prior factors cited above. In each case the item was reviewed and a decision was made based on the content of the item as to the category into which the item fell. The results are presented in Table 3.1.

The next stage in developing this scale involved seeking the opinion of judges who were considered familiar with and knowledgeable about the concept of citizen participation in CMHC boards. A total of 16 judges were selected who had background in the area and

TABLE 3.1.--Distribution of 80 Declarative Statements into Seven A Priori Factors as Predicted by Investigator.

Factor	Number of Statements in Factor
CDM - Control over decision-making	12
RCB - Role of the CMHC Board	17
SAM - Selection and appointment of members	6
RB - Representatives of Board	15
ICP - Impact of Citizen Participation	12
NCP - Need for Citizen Participation	7
PC - Participant Characteristics	11
TOTAL	80

were deemed appropriate to participate in this phase of the study. The first group of these judges was associated with the National Institute of Mental Health (NIMH) citizen participation program which has been an important source of information. Their expertise in the area under study is well recognized, as they are the source for the development of policy relating to citizen participation and governance of federally funded CMHC programs. The three staff members of the program who were contacted readily agreed to participate.

A group of five judges was selected from the Urban Research Center, University of Wisconsin-Milwaukee. This institute had developed a questionnaire which was sent in January 1978 to all federally funded CMHCs under a contract from NIMH's citizen participation program. Because of their expertise and association with NIMH, five staff members were contacted who had worked on developing a scale to measure citizen participation and they also agreed to participate.

Additionally, it was felt that a group of judges should be selected locally from academic departments on the Michigan State University campus who had revealed their expertise in citizen participation either by scholarly work or by actual participation in CMHC boards. A group was selected, based on the personal knowledge of the author and recommendations of faculty members on campus. The distribution of judges is presented in Table 3.2.

Following the selection of the judges but prior to obtaining their responses, review of the 80 declarative statements was completed involving dissertation committee members and one close associate. An effort was made to collapse the a priori factors into fewer than seven categories, but this proved to make differentiation more difficult. Retaining the original seven a priori factors was preferable and prevented considerable overlapping.

TABLE 3.2.--Distribution of Judges by Organizational Affiliation.

Organizational Affiliation	Number of Judges
National	
Urban Research Center - University of Wisconsin-Milwaukee	3
Citizen Participation Program - National Institute of Mental Health	5
Local	
School of Social Work - Michigan State University	3
Department of Psychiatry - Michigan State University	2
Department of Community Health Sciences - Michigan State University	2
Department of Sociology - Michigan State University	1
TOTAL	16

Drafts of the semantic differential scale and demographic variables (Appendix A) were developed in conjunction with the pool of items all of which were reviewed by the dissertation committee members prior to being mailed to the judges.

The 80 declarative statements were arranged randomly and scaled using a Likert format. A change was made involving a shift in the location of the response field to

break the response set. A seven-point scale agree/ disagree continuum (seven being the highest) to ascertain the degree of concurrence with the particular declarative statement under consideration was used. Detailed instructions were developed outlining the four tasks required of the judges for the initial stages of the scale development. The four tasks that the judges were accomplished were to

1. Predict the Directionality of Items. Judges were asked to respond to scale items indicating in their opinion how someone who was strongly identified (i.e., in high agreement) with citizen participation would respond.

2. Estimate the Validity of Content of Scale Items. Judges were asked to suggest different language, new scale items for areas that might have been overlooked and changes in wording, as well as other comments that would help clarify scale items and, hence, the issue under examination.

3. Validate the Seven A Priori Factors Defined Above. Judges were asked to rate each scale item in terms of the categories in which they believe it falls. A provision was made to allow for scale items that were not classifiable, as well as those which overlapped up to two categories.

4. Predict Two High- and Two Low-Scoring Criterion Groups. For the purpose of validating criteria, judges were asked to select groups that, in their opinion, were most divergent in their view of citizen participation in CMHC boards from a list of 29 possibilities:

   A. High-income CMHC board members
   B. Middle-income CMHC board members
   C. Low-income CMHC board members
   D. Members of a CMHC policy board
   E. Members of CMHC advisory board

F. Consumer members of a CMHC board
G. Provider members of a CMHC board
H. Professional staff of a CMHC
I. CMHC directors
J. State hospital staff
K. State hospital directors
L. Department of mental health officials
M. NIMH officials
N. County commissioners
O. County government staff
P. Social agency staff
Q. Social agency directors
R. University faculty
S. High-income consumers of CMHC services
T. Middle-income consumers of CMHC services
U. Low-income consumers of CMHC services
V. High-satisfaction consumers
W. Low-satisfaction consumers
X. Family members of consumers
Y. County community mental health board members
Z. County community mental health board chairpersons
AA. CMHC board chairpersons
BB. County directors
CC. Minority-group consumers of CMHC services

Scales were then mailed to the judges. Returns from the local (Michigan State University) judges were received in seven out of eight scales sent. All seven of the scales were able to be used since they were completely filled out according to instructions. Of the eight scales sent to the national (NIMH and Urban Research Center--University of Wisconsin) experts, six were returned and only two of the six were in a form that could be completely used. Three judges who returned unusable scales were not able to respond fully to the request because they were too busy. Since an insufficient amount of information had been returned by the national judges to warrant inclusion

in the study, the only use made of their returns was to predict two high- and two low-scoring criterion groups (task 4). On this task, the input of 13 returns from six national and seven local judges was used.

The results of the scales returned by the judges were reviewed according to each task completed and yielded the following results for each task:

1. Predict the Direction of Items: The national judges were excluded from the first three tasks because data were incomplete. As seven local judges responded, a positive or negative direction was always discernible due to the odd number of respondents. A Cronbach Alpha for inter-rater and inter-item reliability was calculated on all seven ratesr and all 80 items, respectively. This produced an inter-rater Cronbach Alpha of .91 and an inter-item Cronbach Alpha of .83 for 72 items. Eight items had zero variance and were excluded from the analysis. The two reliability coefficients were well within acceptable limits for the scales.

2. Estimate Validity of Content of Scale Items: Many remarks and comments made by judges were incorporated into a redraft of the scale. Some suggested changes that were implemented included eliminating jargon, clarifying undefined items, eliminating redundant or

repetitive items, and revising the writing to be at a reading level comprehensible to most subjects.

3. Validate the Seven A Priori Factors. The criterion for agreement among judges was set at two different levels to act as a coarse and fine screen to decide whether an item would be retained in a particular factor. The 71 percent or more and 57 percent levels were combined to capture a larger number of items. The first level required agreement among at least five out of seven judges while the second level required four out of seven of the judges to be retained. Hence, for an item to be considered valid with respect to falling into a given factor, there had to be four or more, or at least 57 percent agreement among judges. The results are presented in Table 3.3. One a priori factor (the need for citizen participation) was dropped due to insufficient agreement among the judges, leaving a total of six.

A total of 53 items met the criterion, causing 27 items to be dropped because of insufficient agreement among judges as to the factor which was represented. A comparison of the number of items in each a priori factor as predicted by the author, agreed upon by the judges, and included in the pilot is presented in Table 3.4. Eight additional items were dropped because of duplication and zero variance, leaving a total of 45.

TABLE 3.3.--Two Levels of Agreement among Judges on the Seven A Priori Factors.

	Percent Agreement and Factors							
Percent	CDM	RB	RCB	SAM	ICP	NCP	PC	Total
71+	7	8	4	4	13	1	5	42
57	1	4	1	1	2	0	2	11
TOTAL	8	12	5	5	15	1	7	53

TABLE 3.4.--Comparison of the Number of Items in Each A Priori Factor as Predicted by Author, Agreed upon by Judges, and Finally Included in Pilot.

	Conditions and Factors							
	CDM	RB	RCB	SAM	ICP	NCP	PC	Total
Predicted by Author	12	15	17	6	12	7	11	80
Agreed Upon by Judges	8	12	5	5	15	1	7	53
Included in Pilot	5	12	5	5	12	0	6	45

4. Predict Two High- and Low-Scoring Criterion Groups: For a group to be included as being potentially in agreement or disagreement, at least two judges had to concur. Other groups on the list selected by either one or no judges were excluded. Groups were ranked based upon the number of judges who agreed. In all, 12 groups were considered as possibilities for sampling based on agreement among the judges.

Dr. Byron Van Roekel of the Michigan State University Reading Clinic was consulted and the method of establishing reading level as suggested by Robert Gunning (1952) was used. This method, referred to as the Fog Index, involved estimating the reading level based upon the average sentence length and the percentage of hard words (three or more syllables) per one hundred words. All scale items and instructions were adjusted for a reading level of grades 9 to 10. This reading level was recommended by Dr. Van Roekel based upon the idea that driver's exams administered to the public were of a similar level of reading difficulty. This was necessary because several criterion groups such as clients would have this as their average reading level.

In addition to adjusting the reading level, the demographic items were revised from the original proposal and an additional criterion measure was devised based upon

a conceptual framework suggested by Hunt (1973a). This measure asked the subject to identify the degree of control over the decision-making process from low to high for three board member groups: health care professional members, community leaders, and consumer members.

The total package of instructions, 45 scale items, the semantic differential, the control over decision-making scale, and the demographic items were then assembled and prepared as a pilot (Appendix B) which was administered to 20 professional staff of the Elizabeth Zepf Center (CMHC), Toledo, Ohio, and the South CMHC, Kettering, Ohio. A total of 20 scales was distributed and 19 were returned.

Following a review of this part of the pilot, four of the semantic differential (adjective pairs) items were removed due to the difficulty (three or more syllables) of the words involved. The remaining 15 adjective pairs of the semantic differential were included in the next draft of the questionnaire. The control over decision-making scale was modified to assess the subject's view of this with respect to potential consumers of the Center as differentiated from actual consumers (clients) and the overall decision-making role of the Center's board. In addition to the three member groups mentioned previously (health care professionals, community leaders, consumers) the latter was divided into two groups and the total board

added, making a total of five groups in the revised version of the control over decision-making scale.

This version of the questionnaire was prepared as a preliminary step to using optical scan sheets. Generally, the response was favorable by subjects who completed it but it was difficult to score because of the manner in which the items were arranged. It was anticipated that by using optical scan sheets the process of responding to the questionnaire would be facilitated. The process of reworking the questionnaire on optical scan sheets was followed by a further pilot using Oasis Fellowship members (a Lansing area mental health consumer advocacy group) and MSU graduate students in social work at the Ingham Community Mental Health Center (Lansing, Michigan). A total of 30 questionnaires was distributed in this phase of the pilot and 27 were returned. A total of 46 subjects was used in the analysis of the pilot data.

An analysis of the pilot data revealed a Cronbach Alpha of .79 for 33 items and a correlation coefficient of .53 ($N = 34$, $p < .001$) between the Citizen Participation in CMHC Board's Scale (CPS) and the Semantic Differential. As both statistics were at acceptable levels and there appeared to be no major changes needed in the scale, the decision was made to proceed with the major samples.

Sample Selection

One of the tasks that judges were asked to complete was to predict two high- and two low-scoring criterion groups. Twelve groups received sufficient support from the judges to be considered as possibilities for sampling. Groups considered for sampling were examined with respect to the judge' ratings and as to whether or not it was feasible to actually obtain a sample, considering the numbers of subjects available and the amount of time and cost involved. The decision was made to draw samples from four groups: county community mental health services board members, community mental health center governing/advisory board members, and staff and clients of a community mental health center.

The county community mental health services board members' sample of 100 was selected randomly from a list of approximatley 700 members of the 55-county community mental health services boards in Michigan obtained from the State's Department of Mental Health. The Community Mental Health Center's Governing/Advisory Board members' sample was selected from the federally funded CMHC's in Michigan which currently receive federal funds and are in compliance with the CMHC Amendments of 1975. A letter was sent requesting board member lists and encouraging participation in the research (Appendix C). From this group of nine centers, three boards were unwilling to

participate either because of an overwhelming burden of responsibilities based on the Center's problems or on the general burden of board members' responsibility. The remaining six centers made their board member lists available which totaled 109 members in all and they all received questionnaires. Both samples of 100 and 109, respectively, met the guidelines for size of population and percent of population samples suggested in Engelkes, Livingston and Vandergoot (1975) and developed by Greever, Minton and Tseng (1974). Questionnaires (Appendix D) were mailed to both sample groups with stamped, self-addressed envelopes with instructions for completion and return. A followup reminder post card was mailed 12 days after the initial mailing (Appendix E).

Samples were also drawn from staff and clients of Ingham CMHC (N = 100 each). These samples were limited in their generalizability as they were drawn from only one program in Michigan and in a non-random manner. Michigan Department of Mental Health reviewed the questionnaire for approval on research with human subjects (Appendix F). All client subjects were assured that participation was voluntary, strictly confidential, and in no way was it a prerequisite to their receiving services.

A fifth and final sample was drawn at the National Council of Community Mental Health Centers Annual meeting in Washington, D.C. held during February 22-24, 1979.

This sample consisted of community mental health center board members and staff attending the conference from all parts of the United States. Questionnaires were completed by those people who volunteered. A total of 50 questionnaires was distributed. Table 3.5 indicates the level of return for the five sample groups as of April 17, 1979.

A return rate of 55.6% was obtained in this study. This response rate was considerably better than that which was reported by Nachmais and Nachmais (1976):

> The main problem with mail questionnaires is that of obtaining an adequate response rate. The typical response rate . . . for a mail survey is between 20 and 40 percent . . . . The researcher who uses a mail questionnaire is almost always faced with the problem of how to estimate the effect the nonrespondents may have on his or her findings (pp. 107, 108).

In order to ascertain whether there was anything in the content of the questionnaire which caused subjects not to respond, a sample of 10 percent of the subjects who did not respond was contacted. For the County Community Mental Health Board members, five non-respondents were contacted; for the Community Mental Health Center's board members sample, four members were contacted. Comments included not being members of the Mental Health Board any longer (a 1978 board member list was used and membership had changed in 1979) and not feeling that the questionnaire applied to them, being too busy, having been ill, not receiving the questionnaire, and being out

TABLE 3.5.--Response Rate by Group Samples as of April 17, 1979.

Group	Number Distributed	Number Returned	Percent
Pilot (OASIS Fellowship, Ingham CMHC Students and Staff of Two CMHC's in Ohio	50	46	92.0
National Council of CMHC Meeting	50	28	56.0
County CMH Services Board Members	100	50	50.0
CMHC Advisory/Governing Board Members	109	63	57.8
Ingham CMHC Staff	100	66	66.0
Ingham CMHC Clients	100	30	30.0
TOTAL	509	283	55.6

of town. All non-respondents reported that there was nothing specific to the questionnaire that had caused them not to respond.

Following telephone contact with the non-respondent County and CMHC board members, a second questionnaire was sent requesting that it be completed and returned in 10 days. Table 3.6 depicts the results of this mailing to non-respondents. Although non-respondents and respondents appeared to be similar from the narrative remarks collected

TABLE 3.6.--Non-Respondents' Rate of Return.

Group	Number Distributed	Number Returned	Percent
County CMH Services Board Members	5	5	100
CMHC Advisory/Governing Board Members	4	2	50
TOTAL	9	7	77.77

in telephone contact, a one-way ANOVA indicated that the mean of the non-respondents was higher than the mean of the respondents ($p < .01$). This would suggest that non-respondents had a more favorable attitude toward citizen participation in CMHC boards. This was counter to what might be expected since it is generally thought that non-respondents harbor negative opinions. The small numbers involved in the sampling of non-respondents would raise questions as to the validity of any conclusions based upon these data. Table 3.7 is a summary of these findings.

As the staff sample return rate was over 60 percent, non-respondents were not sampled. With reference to clients, it was not possible to contact non-respondents because questionnaires were given only to clients that agreed to complete them, and it would be redundant to contact clients regarding their participation. There was

TABLE 3.7.--One-Way ANOVA--Citizen Participation Scale (CPS) Total Score by Non-Respondents versus Respondents.

Group	Number	Mean	Standard Deviation	Standard Error
Non-Respondents	7	151.79	14.05	5.31
Respondents	270	134.52	17.46	1.06
TOTAL	277	134.96	17.57	1.06

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	1	2033.47	2033.47	6.72	.01
Within Groups	275	83185.80	302.49		
TOTAL	276	85219.28			

concern that clients not be pursued if they chose not to respond. Staff members who had experience in distributing the questionnaire to the clients stated that the length and complicated nature of the questionnaire was responsible for clients opting not to complete the task, rather than anything related to the content.

Reliability analysis was conducted on the data following the completion of the sampling procedure. A total of 290 cases were used in the analysis producing a

Cronbach Alpha of .66 for 45 items (N = 277, p < .0001). Reliability coefficients were not sufficient to claim internal consistency for the six a priori factors. As scale reliability could be increased by dropping several items that were not contributing sufficiently to total scale reliability, a second run was completed, dropping four items with weak item total correlations and raising the Cronbach Alpha to .72 on 41 items (N = 277, p < .0001). A Cronbach Alpha of .83 (N = 252, p < .0001) was computed for the 15 semantic differential items. A factor analysis was performed for eight factors which did not produce a confirmation of the a priori factors. Pearson correlation coefficient for the reduced total scale (41) items and the semantic differential was .54 (N = 247, p < .0001). No strong relationships were found between the 41-item scale and the control over decision-making items (second set of criteria variables).

The reliability analysis was continued by dropping scale items that were weak (< .10 item-total r), and each time the reliability improved. Once the scale dropped below 27 items, the reliability began to decline rather than improve and it was decided that from a practical as well as statistical standpoint, 30 items would constitute a scale of optimal length. All further analysis was then conducted on the 30-item scale, Citizen Participation in CMHC boards scale (CPS). Tables 3.8 and 3.9 summarize the

TABLE 3.8.--Reliability Analysis, Cronbach Alpha by Number of Scale Items on CPS.

Number of Scale Items	Cronbach Alpha
45	.66
41	.71
38	.74
35	.76
30	.78
27	.79
23	.78

data for the reliability analysis and item analysis for the scale.

Research Hypotheses

Based upon the research questions proposed in Chapter I the following hypotheses were investigated in this study:

1. There will be a negative relationship between a favorable attitude toward citizen participation in CMHC boards and income.

2. There will be a negative relationship between a positive attitude toward citizen participation in CMHC boards and age.

TABLE 3.9.--Means, Standard Deviations and Item-Total Correlation Coefficients for the 30-Item Citizen Participation in CMHC Boards Scale (CPS)

	Mean	Standard Deviation	Item Total r
1. Citizen board members should vote on issues affecting the CMHC but their choices should be able to be changed by the center's director.*	4.31	1.80	.23
2. People who have used the center should be represented on the CMHC Board.	4.77	1.54	.29
3. Citizen board members should be elected to the CMHC board by local people rather than be appointed by the county or city.	3.91	1.98	.17
4. Citizen members of the board should be involved in the hiring and firing of the CMHC director.	4.94	1.51	.45
5. What the CMHC board has accomplished should be a factor in looking at the results of citizens taking part in CMHC boards.	4.90	1.45	.27
6. Citizen members of CMHC boards should be selected for their drive and because they are leaders.	4.10	1.57	.16
7. Citizen members of the CMHC board should represent a sample of all parts of the area served by the program.	5.57	.94	.27
8. CMHC boards should be made up of mostly mental health professionals.*	4.34	1.51	.40
9. Citizen board members should serve on CMHC governing boards instead of advisory boards.	3.93	1.78	.32
10. Local businessmen should be asked to be members of CMHC boards	4.72	1.55	.36
11. Those named to CMHC boards should be approved by the State Mental Health Department.*	4.81	1.60	.18
12. Citizen board members would have the most effect when they are appointed by the county.*	4.29	1.73	.18
13. If citizen board members are involved in policy making, mental health professionals are not likely to want to work in CMHC's.*	4.62	1.61	.34
14. Every CMHC should have persons serving on the board who have used the services.	4.07	1.76	.25
15. Citizen board members should share in policy making with those who hold the power in the CMHC.	4.82	1.56	.40
16. Citizens sharing in the planning and running of CMHC's have not produced enough payoff to make it worthwhile.*	4.68	1.38	.34

*disagree items

TABLE 3.9.--Continued

	Mean	Standard Deviation	Item Total r
17. A volunteer program would have more effect on involving citizens in the CMHC than having them serve on the board.*	3.93	1.70	.22
18. Citizen board members should have the power to make decisions such as approving the CMHC budget.	4.36	1.84	.46
19. Those who are active on other civic boards should make the most effective members of the CMHC boards.	3.37	1.54	.24
20. Citizens taking part in CMHC boards would have an impact on changing how staff treats clients.	4.20	1.74	.29
21. Greater citizen input would hinder the work between the CMHC and other social agencies.*	4.66	1.57	.33
22. Greater citizen input in CMHC boards would reduce staff efficiency.*	4.75	1.51	.31
23. Those who are good at speaking for the community should serve on the board to help to increase the use of the center.	4.53	1.57	.39
24. Having citizens take part in CMHC boards would be a way of training local people in democratic values.	4.00	1.64	.22
25. Citizens taking part in CMHC boards would be most effective if their role is clearly defined.	5.40	1.16	.15
26. CMHC boards should sponsor forums to inform the public about problems of servicing the area.	5.29	1.27	.30
27. Militant social action groups should be allowed to take part in the planning of CMHC services.	3.40	1.84	.29
28. Greater citizen input would bring greater public support for the CHMC.	5.20	1.17	.35
29. Local political leaders should be on the board of the CMHC.	3.69	1.73	.29
30. Citizen members of CMHC boards should be asked about policies before they are made.	4.90	1.48	.29

*disagree items.

3. There will be a positive relationship between a favorable attitude toward citizen participation in CMHC boards and being male.

4. There will be a positive relationship between a favorable attitude toward citizen participation in CMHC boards and education.

5. There will be a positive relationship between being married and favorable attitude toward citizen participation in CMHC boards.

6. There will be a positive relationship between a favorable attitude toward citizen participation in CMHC boards and level of community activity.

7. There will be a differentiation between group means at the $p < .05$ level of significance with regard to citizen participation in CMHC boards.

Statistical Analysis

A variety of analyses were used in this study. The computer programs used for these analyses were all part of the Statistical Package for the Social Sciences (1975) and the analyses were computed on the CDC 6500 computer at Michigan State University. Analysis of variance was used to test for significant differences between the means of the groups that were sampled. Where further analysis was required so as to find specific significant differences between paired group means, contrasts were established and evaluated with t-tests. Pearson product moment correlations were used to examine

relationships between variables. In order to further examine the data, one-way analysis of variance was used. Reliability analyses were conducted using the Cronbach Alpha. The Cronbach Alpha is ". . . the mean of all split-half coefficients resulting from different splittings of a test . . . [Cronbach Alpha] is therefore an estimate of the correlation between two random samples of items from a universe of items . . ." (Cronbach, 1951, p. 132).

Summary

In this chapter the procedures for developing the 30-item Likert scale were described in detail. Based upon the review of the literature, 80 declarative statements were scaled in an agree-disagree format and six a priori factors were validated by experts in the field of citizen participation in CMHC boards. In addition, the experts predicted high- and low-scoring criterion groups, item directionality and reviewed the content validity of the scale. The reading level of the scale was adjusted for 9th - 10th grade. Demographic items and two criterion measures (semantic differential and a control over decision making scale) were developed prior to piloting. Piloting of the scales was accomplished on graduate social work students at the Ingham CMHC, Oasis Fellowship, Inc. (a consumer advocacy group) and staff of two CMHC's in

Ohio. A reliability of .79 and a validity of .53 were considered sufficient to continue with the major study.

Major samples included those in attendance at the National Council of CMHC's meeting February 1978, in Washington, D.C., randomly selected County Community Mental health board members, and CMHC board members, staff, and clients of the Ingham CMHC. An overall return rate of 55.6% was reported for a total of 509 questionnaires sent. Non-respondents were surveyed and differed from respondents at the .01 level of significance. The 30-item scale had a reliability of .78 and concurrent validity of .52 with the semantic differential. Weak relationships were found for the second criterion measure.

CHAPTER IV

RESULTS

Introductory Statement

The purpose of this study was to develop an instrument to measure the variable: attitude toward citizen participation in Community Mental Health Center (CMHC) boards. In this chapter the results of the study will be presented as they relate to the development of the Citizen Participation Scale (CPS). This analysis will focus on differences and relationships among variables. Because a large number of subjects participated in the study, considerations of practical versus statistical significance must be kept in mind.

Each hypothesis is restated from Chapter III, with the statistical analysis immediately following. For testing each of the hypotheses, the citizen participation scale (CPS) of 30 items was used. The question numbers refer to the scale in Appendix D.

Results of Analyses

Hypothesis 1:

> There will be a negative relationship between a favorable attitude toward citizen participation in the CMHC Mental Health Boards and income.

The data for Hypothesis 1 related variable CPS to the gross annual income (Question 7). The Pearson correlation for these variables was .11 (N = 271, p < .04) which indicated non-support of the hypothesis. In addition, a one-way ANOVA was done to detect differences among the six income groups. The data did not support the possibility that there were differences in the means among the income groups (Table 4.1).

Hypothesis 2:

> There will be a negative relationship between a positive attitude toward citizen participation in CMHC boards and age.

The data for Hypothesis 2 related the variable CPS to age (Question 4). The Pearson correlation coefficient for these variables was .14 (N = 276, p < .07) which indicated weak relationship and non-support of the hypothesis. Additionally, a one-way ANOVA was done which indicated that the differences among the means of the various age groupings was not significant (Table 4.2).

Hypothesis 3:

> There will be a positive relationship between a favorable attitude toward citizen participation in CMHC boards and being male.

The data for Hypothesis 3 related the variable CPS to sex (Question 5). The Pearson correlation for these variables was -.04 (N = 265, p < .28) which

TABLE 4.1.--One-Way Anova--CPS Total Score by Income.*

Group	Number	Mean	Standard Deviation	Standard Error
$ 4,999 or under	15	131.63	16.23	4.19
$ 5,000 - $ 9,999	20	130.88	16.85	3.77
$10,000 - $14,999	38	134.26	13.76	2.23
$15,000 - $19,999	34	132.72	25.03	4.29
$20,000 - $29,999	82	134.35	16.97	1.87
$30,000 and over	82	137.78	16.56	1.83
TOTAL	271	134.77	17.60	1.07

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	5	1360.94	272.19	.88	.50
Within Groups	265	82287.93	310.52		
TOTAL	270	83648.87			

*NOTE: In subsequent tables variable N sizes will be noted due to differential response rates to various items.

TABLE 4.2.--One-Way ANOVA--CPS Total Score by Age.

Group (yrs)	Number	Mean	Standard Deviation	Standard Error
19-24	16	126.06	12.83	3.21
25-29	40	136.55	17.47	2.76
30-34	39	134.23	16.56	2.65
35-39	44	130.20	18.00	2.87
40.44	27	132.63	21.21	4.08
45-49	26	137.15	20.38	4.00
50-54	35	137.51	17.43	2.95
55-65	35	139.00	14.29	2.42
66 and over	14	139.61	9.31	2.49
TOTAL	276	134.86	17.53	1.06

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	8	3754.72	469.34	1.55	.14
Within Groups	267	80783.93	302.56		
TOTAL	275	84538.65			

indicated no relationship and non-support of the hypothesis. Additional analysis of the differences among groups means was non-significant when using a one-way ANOVA (Table 4.3).

Hypothesis 4:

> There will be a positive relationship between a favorable attitude toward citizen participation in CMHC boards and education.

The data for Hypothesis 4 related the variable CPS to education (Question 6). The Pearson correlation coefficients for these variables were .01 ($N = 274$, $p < .001$) which indicated a statistically significant relationship and support of the hypothesis. Additional analysis of the means of the educational groupings indicated significant differences at the .005 level (Table 4.4).

Hypothesis 5:

> There will be a positive relationship between being married and a favorable attitude toward citizen participation in CMHC boards.

The data for Hypothesis 5 related the variable CPS to marital status (Question 5). The Pearson correlation coefficient for these variables were .09 ($N = 265$, $p < .07$) which indicated no relationship and non-support for the hypothesis. One-way ANOVA for the means indicated no significant differences (Table 4.5).

TABLE 4.3.--One-Way ANOVA--CPS Total Score by Sex.

Group	Number	Mean	Standard Deviation	Standard Error
Male	121	135.75	16.83	1.53
Female	144	134.53	17.55	1.46
TOTAL	265	135.09	17.21	1.06

Analysis of Variance

	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	1	97.33	97.33	.33	.57
Within Groups	263	78056.67	296.79		
TOTAL	264	78154.00			

TABLE 4.4.--One-Way ANOVA--CPS Total Score by Education.

Group	Count	Mean	Standard Deviation	Standard Error
Some High School	5	121.70	10.40	4.65
High School Graduate	24	124.42	16.78	3.43
Technical School	5	121.20	19.71	8.81
Some College	44	136.03	12.81	1.93
College Grad.	48	136.92	18.19	2.63
Graduate or Professional School	148	134.91	18.25	1.50
TOTAL	274	134.91	17.66	1.07

Analysis of Variance

	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	5	5098.97	1019.79	3.41	.005
Within Groups	268	80046.76	298.68		
TOTAL	273	85145.73			

TABLE 4.5.--One-Way ANOVA--CPS Total Score by Marital Status.

	Number	Mean	Standard Deviation	Standard Error
Married	183	136.52	15.60	1.15
Single	35	130.59	21.78	3.68
Widowed	8	132.63	11.72	4.14
Separated-Divorced	39	132.92	20.18	3.23
TOTAL	265	135.09	17.21	1.06

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	3	1314.17	438.06	1.49	.22
Within Groups	261	76839.84	294.41		
TOTAL	264	78154.01			

Hypothesis 6:

> There will be a positive relationship between a favorable attitude toward citizen participation in CMHC boards and level of community activity.

The data for Hypothesis 6 related the variable CPS to hours spent in community activities such as participation in boards and volunteer work (Question 14). The Pearson correlation coefficient for these variables were -.05 ($N = 277$, $p < .19$) which indicated no relationship and non-support for the hypothesis.

Further questions were explored related to the demographic variables such as whether the instrument could differentiate between board chairpersons and board members, board members who were elected officials and non-elected official board members, professionals and non-professionals, board members and non-board members, consumers and non-consumers, and minority and non-minority subjects. One-way ANOVA was performed on each of these groups and significance at the .05 level was found between the means of the board members and non-board members and minority and non-minority subjects. The data are presented in Tables 4.6 through 4.11.

Hypothesis 7:

> There will be a differentiation between group means at $p < .05$ level of significance with regard to citizen participation in CMHC boards.

TABLE 4.6.--One-Way ANOVA--CPS Total Score by Board Chairperson versus Board Members.

	Number	Mean	Standard Deviation	Standard Error
Community Mental Health Board Chairman	17	141.53	13.45	3.26
Community Mental Health Board Members	98	141.02	17.81	1.80
TOTAL	115	141.09	17.19	1.60

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	Ratio	Prob.
Between Groups	1	3.83	3.83	.01	.91
Within Groups	113	33678.96	298.04		
TOTAL	114	33682.79			

TABLE 4.7.--One-Way ANOVA--CPS Total Score by Elected Officials versus Non-elected Officials Who are Board Members.

Group	Number	Mean	Standard Deviation	Standard Error
Board Members Who are Elected Officials	31	138.95	18.67	3.35
Board Members Who are Not Elected Officials	86	141.53	16.63	1.79
TOTAL	117	140.85	17.15	1.59

Analysis of Variance

	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	1	152.06	152.06	.51	.47
Within Groups	115	33971.07	295.40		
TOTAL	116	34123.13			

TABLE 4.8.--One-Way ANOVA--CPS Total Score by Professionals versus Non-professionals.

Group	Number	Mean	Standard Deviation	Standard Error
Professionals	117	133.84	17.44	1.61
Non-professionals	160	135.78	17.67	1.40
TOTAL	227	134.96	17.57	1.06

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	1	252.55	252.55	.82	.37
Within Groups	275	84966.72	308.97		
TOTAL	276	85219.27			

TABLE 4.9.--One-Way ANOVA--CPS Total Score Board Members versus Non-board Members

Group	Number	Mean	Stamdard Deviation	Standard Error
Board Members	117	140.85	17.15	1.59
Non-board Members	160	130.65	16.65	1.32
TOTAL	277	134.96	17.57	1.06

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	1	7031.74	7031.74	24.73	.001
Within Groups	275	78187.53	264.32		
TOTAL	276	85219.27			

TABLE 4.10.--One-Way ANOVA--CPS Total Score by Consumers versus Non-consumers.

Group	Number	Mean	Standard Deviation	Standard Error
Consumer	116	133.06	17.49	1.62
Non-consumer	158	136.34	17.72	1.41
TOTAL	274	134.95	17.66	1.07

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	1	721.65	721.65	2.32	.13
Within Groups	272	84464.53	310.53		
TOTAL	273	85186.18			

TABLE 4.11.--One-Way ANOVA--CPS Total Score by Race.

Group	Number	Mean	Standard Deviation	Standard Error
White	248	134.05	17.29	1.10
Non-white	29	142.69	18.39	3.41
TOTAL	227	134.96	17.57	1.05

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between Groups	1	1936.05	1936.05	6.39	.01
Within Groups	275	83283.22	302.85		
TOTAL	276	85219.27			

This analysis was undertaken to explore the question of significance between the groups that took the scale. A confirmation of this would indicate that the instrument has the ability to discriminate among various groups along a continuum of those favorable toward citizen participation in CMHC boards. Confirmation of this pattern would indicate the instrument's basic construct validity. An eight-cell one-way ANOVA was performed to test for significance and, in addition, contrasts were formulated for the 28 pairs of group means. Significance was reported at the $p < .001$ level for an N of 276 for all eight groups. The paired contrasts for the different groups revealed 14 differences $p < .01$. The matrix reflects a pattern that is consistent in most respects to that which would be expected (Tables 4.12 and 4.13).

Summary

The results of the study were presented in this chapter. The findings were reported in two categories; the first related to the development of the scale and the second described the relationships between the scale and various demographic variables.

A 30-item Likert scale was developed with a reliability of Cronbach Alpha of .78. The concurrent validity of the scale with the 15-item semantic differential was found to be .52 ($N = 247$, $p < .001$). The

TABLE 4.12.--One-Way ANOVA--CPS Total Score by Criterion Groups.

Group	Number	Mean	Standard Deviation	Range	Standard Error
CMHC Governing Board Members	43	148.07	20.58	59 -178	3.14
National Council CMHC's Meeting	25	137.82	5.50	128 -150	1.10
County CMH Services Board Members	50	136.91	15.14	95.5-162.5	2.14
Staff of Two CMHC's in Ohio	34	136.53	15.88	114 -172	2.72
CMHC Advisory Board Members	19	136.11	10.62	113 -159	2.44
OASIS Fellowship	12	130.29	6.84	119 -140	1.97
Ingham CMH Staff	67	128.69	17.41	82.5-167.6	2.13
Ingham CMH Clients	27	122.66	19.35	64 -158	3.72
TOTAL	277	134.96	17.57	59 -178	1.06

Analysis of Variance

Source	DF	Sum of Squares	Mean Squares	F Ratio
Between Groups	7	14872.29	2124.61	8.12*
Within Groups	269	70346.98	261.51	
TOTAL	276	85219.27	261.51	

*$p < .001$

TABLE 4.13.--t Tests of Contrasts of Mean Scores for Criterion Groups on CPS

Group	National Council on CMHCs Meeting	County CMH Services Board Members	Staff of Two Ohio CMHC's	CMHC Advisory Board Members	OASIS Fellowship	Ingham CMHC Staff	Ingham CMHC Clients
CMHC Governing Board Members	3.081+	-2.937+	2.777+	3.011+	-4.795*	-5.113*	-5.22*
National Council on CMHCs Meeting		-.378	-.439	-.641	-3.330+	-3.814*	-3.90*
County CMH Services Board Members			.110	.248	2.273	-2.725+	-3.32+
Staff of Two Ohio CMHC's				-.116	-1.855	-2.270	-3.01+
CMHC Advisory Board Members					-1.854	-2.294	-3.02+
OASIS Fellowship						-.553	-1.81
Ingham CMHC Staff							-1.40

*p < .001 +p < .01

concurrent validity of the scale with five other criteria variables indicated weak, statistically significant relationships between the scale and a high level of control over decision making for community leaders, potential consumers, and for the entire board as opposed to clients and mental health professionals. The construct validity of the instrument was supported as the ordering of group means was as expected, with board members being most in favor of a strong citizen role while staff was less favorable.

A weak, statistically significant relationship was found between a favorable attitude toward citizen participation and a high level of education. The data suggest also that those who are older and who have a higher level of income would also support a strong citizen role. Minorities and board members scored significantly higher on the scale, indicating their attitude of being in favor of a high level of citizen participation. Clients and parents of clients, while supported by "liberal" professionals to take an active role in the governance of CMHC services, seem almost as opposed to the idea as the professionals.

CHAPTER V

DISCUSSION

Introductory Statement

This research was conducted to evaluate several questions related to citizen participation in Community Mental Health Center (CMHC) boards. The primary questions of this study were as follows:

1. Can an instrument be developed to measure the attitude toward citizen participation in CMHC matters by varying constituencies?
2. Is the attitude toward citizen participation in CMHC boards held by groups such as clients, staff, and board members significantly different?
3. How do the variables of age, sex, income, education, and level of community activity relate to the attitude toward citizen participation in CMHC boards?

These questions produced research findings which will be discussed separately in the following sections of this chapter. The first two sections focus on instrument development and related issues, while the third section elaborates upon the scale and various demographic characteristics. Limitations of the research, implications for future research, and conclusions are then presented in the final sections.

Results of the Instrument Development

A 30-item Likert scale was developed which had a reliability of Cronbach Alpha - .78. The reliability was within acceptable limits for attitude scales, which is typically .75 (Mehrens & Lehmann, 1969, p. 257). A moderate level of relationship (.52) with one of the two criterion measures, namely, the semantic differential was found and a statistically significant and weak relationship was found between the citizen participation scale (CPS) and the five-item control over decision-making scale. The construct validity of the instrument was verified in a review of the contrasts between the means of the criterion groups. Significant differences were found among the groups which will be discussed in more detail in the next section. The factor analysis that was completed for the scale did not support the six a priori factors (control over the decision-making process, role of CMHC board, selection and appointment of members, representativeness of board, impact of citizen participation, and participant characteristics) validated by the judges in the early phase of the research.

The validity for attitude measures is usually quite low. Values in the range of .5 to .6 are not unusual (Tittle & Hill, 1967; Mehrens & Lehmann, 1969, p. 258). Of the two measures of concurrent validity, the value produced by the semantic differential, an instrument

with adequate research support, was superior to the five-item control over decision-making scale. The data supported the characteristics of reliability and validity associated with a typical Likert Scale. Since these scales depend on the self-reporting of the subject where it is possible to hide one's true attitudes, caution should be exercised when interpreting these scores. However, for research purposes these scales represent the "state of the art" and are the best that are available.

The factor analysis did not support the six a priori factors. A possible explanation for this was that the area of study is highly complex and that the scale items developed did not lend themselves to simple categorization. The scale was consequently treated as a single variable.

Results Related to Differences Between Criterion Groups on the Citizen Participation Scale (CPS)

A one-way ANOVA was conducted to demonstrate the scale's construct validity on the eight groups indicating a high level of significance ($p < .001$) between the means of the consumer, staff, and board member groups. In order to determine where the statistical significance was specifically, 28 paired comparisons were established among the eight groups. Differences were found ($p < .001$) between clients of the Ingham CMHC and CMHC board members

in Wayne County. Other significant differences were found reflecting a trend in the data to indicate that those board members most associated with the governance of the CMHC are most in favor of citizen participation, while those whom the organization most affects--clients, clients' parents (consumer advocates), and staff--were less in favor of a strong citizen role.

One would expect governing board members of CMHC's in Wayne County to be highly in favor of a strong role for citizens in the governance of the center. The CMHC's in Wayne County are private non-profit corporations which can appoint their own board members from a variety of neighborhood organizations. As such the centers provide a model which is "grass roots" oriented and closely related to the model of governance proposed in federal CMHC legislation. As pointed out in the review of literature, federal programs in the 1960s often directed support to the local level of "fight city hall," thereby stimulating local citizen participation. Interestingly, the Wayne County governing board members were significantly higher-scoring than all other groups tested.

An inconsistency in the data was reflected in the lack of similarity between the means of the Wayne County governing board member group and that of the National Council of CMHCs. Since the National Council of CMHCs is comprised of federally funded centers, it was expected

that they would view citizen participation quite similarly to the Wayne County group. Since the National Council of CMHCs group was composed of both staff and board members (split about evenly), the influence of the staff which tended to score lower on the scale (Ohio and Ingham CMHC staff), may account for the somewhat lower than expected group mean.

A review of the data for Oasis Fellowship, clients and CMHC staff revealed some interesting observations. Oasis Fellowship consisted of clients' parents who were attempting to become consumer advocates. Consumerism has been with us in force for the last several years. Individuals such as Ralph Nader who were associated with the beginnings of the movement through his work on safety in the automobile industry, have expanded their interest to the area of health and mental health care (Chu & Trotter, 1974). If one were to generalize Nader's premise that mental health services ought to be influenced strongly by actual consumers (clients), and potential consumers who are most closely affected by or most likely to be affected by mental health services, then a strong citizen role in the determination of how those services were to be offered would be expected. Interestingly, when this thought was tested, the data did not support it. While the concept of citizen/consumer participation is most heavily supported by the board members themselves as opposed to the

professional staff, the clients and Oasis Fellowship were more closely aligned with the professionals than the citizen board members. This finding adds support to what was personally experienced.

It was paradoxical that groups which would be most affected by the services, clients and their family members, were the least in favor of their having a strong voice in defining CMHC directions. At the same time, clients and their families are often most critical of the quality and quantity of the mental health services which they use. Perhaps it is characteristic of this particular handicapping condition that those most affected by it are least able to take political action to foster change in the services available. If one would exclude the clients themselves from this group because of their limited ability to function in this area, then the families should be most available as advocates on the client's behalf. This has been observed with parents of the mentally retarded for many years but has only recently become a factor with groups representing the psychiatrically impaired. Several years ago the author would have hypothesized that parents and clients would have scored even lower on the CPS scale than they did. Perhaps the fact that they did score higher than expected is reflective of a change. It is anticipated that in the future they will play as active a role as the present

board members and will, in fact, be vying for seats on mental health boards which will enable them to accomplish their goal.

Other conclusions can be drawn from the data. The data supported the idea that governing board members would score higher than advisory board members. This indicated that those board members actually involved in policy-making supported a stronger role for citizens in that policy-making as opposed to board members in an advisory role who often questioned their impact on the CMHC. County board members and CMHC governing board members were significantly different, as would be expected, since CMHC governing board members are generally comprised of people who are not political appointments.

Results Related to the Relationship Between Demographic Characteristics and the Citizen Participation Scale (CPS)

Of the demographic correlates studied (age, marital status, sex, level of education, income and community activity) only education was at all suggestive of being related to CPS. The relationship was weak (.21) which accounted for only four percent of the common variance among variables. The correlation, which was statistically significant but at such a low level of relationship, had little practical value.

In terms of the differences among groups, statistical significance was found in three instances: whether or not the subjects attended college, whether or not they were members of a minority group, and whether or not they were board members. Those who had some college or had completed college, were members of a minority group, and were board members tended to score significantly higher on the CPS.

The results of this part of the study supported the conclusions cited in the preceding section. As expected, the Wayne County CMHC governing board members were highly supportive of a strong role for citizen participation. It was clear that the subjects who scored higher in the study came from this group, scoring on the average at least 10 points higher than any other group. A plausible explanation for the results related to demographic characteristics could be that minority board members in Wayne County played an active role in community affairs in a county which has a significant population of minority group members. Those who served on boards tended to be upwardly mobile and more highly educated. This was an interesting contradiction in terms since there appeared to be a tendency not to identify with one's immediate past while at the same time being expected to represent the interests of actual and potential consumers of publicly supported CMHC services. The data,

then, supported the notion that board members who were somewhat more educated and members of minority groups were the most likely to receive a high score on the CPS. Those who were most involved as CMHC governing board members were apparently the strongest supporters of citizen participation in CMHC boards, a result which is obvious and not surprising.

Limitations of the Research

Caution must be exercised when generalizing the results of this study. The County Community Mental Health board members, CMHC board members, and advisory board member samples were selected randomly from the population of board members in Michigan. The results of the study with respect to these samples could be considered valid for Michigan but probably not for board members on a national level due to the many differences between CMHC programs in various states.

Sample sizes for clients, staff, and Oasis Fellowship were quite small and not randomly selected due to financial limitations. Clients and staff were selected from only one CMHC in Michigan and in the case of the clients, a very low return rate was prevalent. Non-respondent clients could not be sampled because of concerns about client confidentiality and a general desire on the part of the clients' therapists not to pursue the

completion of the scale if it were not returned immediately.

Oasis Fellowship, a group of parents of young adults who are mentally ill and who were currently involved in some level of consumer advocacy, were unique to the Lansing area. Due to financial limitations, no effort was made to find and sample other similar groups in Michigan. It was not clear whether any other groups of this type have been organized in other parts of the state. If so, they do not communicate with each other and consequently have no knowledge of each other's activities.

The samples of staff in the two Ohio CMHCs and those at the National Council of CMHCs meeting were not selected randomly. Subjects in both groups were selected because they were available as volunteers, and results related to these groups should be interpreted with caution. Non-respondents sampled following the cut-off date for the main samples of county community mental health board members and CMHC governing and advisory board members scored significantly higher than the respondents. Telephone interviews were conducted in addition to mailing a second questionnaire and the interviews indicated a positive attitude toward citizen participation in CMHC boards and completing the task. The fact that non-respondents scored higher than respondents

indicated a favorable attitude toward citizen participation and validated the reasons (i.e., being too busy, not receiving the questionnaire) given by non-respondents rather than the reason being the content of the questionnaire. Here, too, caution should be exercised in the interpretation due to the very small sample involved.

Implications for Future Research

This study raised many questions in addition to the immediate ones it set out to answer. By developing an instrument it was expected that efforts to evaluate, measure, and, in some way, quantify the concept of citizen participation in CMHC boards would be achieved. Many possibilities remain for expanding this research.

As mentioned above, some of the samples were not randomly selected due to the financial limitations of the study. Additional data could be gathered that would allow greater generalization to CMHC clients and staff. Other groups could be sampled, such as staff in state hospitals, board members from CMHCs in other states, the general public, and those who train mental health professionals at various universities. Differences among mental health professionals could be explored. Generally, a broadening as well as a careful selection of additional norm groups could add another dimension to the area of research initiated in this study. Demographic

characteristics of the various groups could be explored in more detail. Relationship to other variables for which scales are already in existence could be explored relative to the CPS.

One of the original purposes of this study was to create an instrument which could measure one of the independent variables that affect the effectiveness of a CMHC board. With a suitable criterion measure, it would be possible to assess the impact of the attitude of board members on the actual level of accomplishment or effectiveness of a CMHC board.

As a predictive measure, the CPS could be used as a means of determining where a potential board member stood in terms of his/her attitude toward citizen participation. It is possible that the nominating committee of a CMHC board would want to use this information in making a decision about whether or not to offer an appointment to the board. Use of the CPS could address the concern that the CMHC board have a balanced composition with respect to being supportive of citizen/consumer interest. Since boards of CMHCs are to be representative of the community, use of the CPS may promote some assurance that a broad range of attitudes might be represented.

The CPS could be used as a measure of results (outcome) to assess the impact of board member training

programs upon attitude toward citizen participation in CMHC boards. Recently articles have appeared (e.g., Howell, 1979) presenting a model of training to develop board members and make them effective. The CPS could be used as a pretest and posttest for measuring the effect of thetraining program on board member attitude toward citizen participation in CMHC boards. Training packages producing no measurable results could be eliminated or modified, saving time and limited financial resources.

A final question raised by this research relates to the effect of citizen participation or consumer control on the delivery of mental health services. Two authors (Tischler, 1971, and Bolman, 1972) cite their rather different experiences in this area. For Tischler (1971) a shift from informal citizen participation to more formal community control caused a reordering of program priorities (i.e., emphasizing children's services) and modifications in staff task characterized by four basic patterns: (1) fear and disorganization; (2) retrenchment and denial; (3) romance and surrender; and (4) collaborative engagement. "All but the last [pattern] tended to compromise the staff's capacity to perform their assigned roles and therefore had an adverse effect upon the delivery of service" (p. 505). Bolman (1972) cites examples from clinical practice which illustrate the issues raised as a result of community control of mental health centers. The

examples are characterized by consumer dissatisfaction, institutional inability to respond and black-white conflict. A concerted effort on the part of professionals to work closely with citizen/consumer groups is urged by Bolman to overcome these obstacles to the effective delivery of mental health services. Further research into the coordination of effort between the CMHC staff and board members for increased program effectiveness is urgently needed and hopefully the research presented herein can be a base upon which further investigation may be built.

Conclusions

The purpose of this research was to develop a means of measuring the attitude toward and effectiveness of citizen participation in CMHC boards. This study has produced the following findings related to this goal:

1. A reasonably reliable and valid instrument was produced which could measure the attitude under investigation.

2. Generally those in favor of citizen participation saw community leaders and potential consumers rather than actual consumers (clients) and mental health professionals as being able to play a strong role in CMHC decision-making.

3. Correlations between demographic variables and the citizen participation scale suggest that those who are more educated support a strong citizen role in decision-making.

4. Minorities and board members were found to be in favor of a strong citizen role.

5. The construct validity of the scale was supported, showing governing board members being most in favor of a strong citizen role and mental health professionals least in favor.

6. Clients and parents of clients unexpectedly were aligned with the professionals in not supporting a strong citizen/consumer role in mental health decision-making.

Citizen participation has permeated many areas of American life and is closely associated with the basic tenets of democracy. While citizen participation in community mental health services is a recent idea, it is based upon many years of participatory democracy in American institutions such as public schools. This study sought to clarify the concept, measure attitudes, and contribute toward accomplishing a quantifiable means of evaluating its effectiveness. The results of this study have supported the idea that much clarification was and still is needed. It is hoped that this research has also contributed to the ability to evaluate the effectiveness of citizen participation, the acid test as to whether efforts to improve community agencies' responsiveness actually produces the intended results.

APPENDICES

APPENDIX A

MAILING TO JUDGES: FOUR TASKS FOR INITIAL STAGES OF SCALE DEVELOPMENT

Dear

Thank you for agreeing to be a judge for the development of this scale. I believe, as I'm sure you do, that citizen participation in the delivery of community mental health services is an important area that requires much study and research in order to increase the understanding and, hence, the effectiveness of this endeavor.

I would like to draw on your expertise in the area and have you review the enclosed first draft of this scale in terms of four tasks that need to be accomplished.

These are as follows:

1) Predict two high and two low scoring criterion groups.

2) Predict the directionality of the scale items.

3) Estimate the content validity of the scale items.

4) Validate the seven factors of the scale.

Also enclosed is the scale entitled, "A Scale to Measure Attitudes Toward Citizen Participation in Community Mental Health Center Boards" and more detailed instructions as to how to proceed with the above-mentioned tasks.

Your time and assistance with these tasks is appreciated. The results of the study will be forwarded to you at a later date.

If you have any questions, please contact me.

Sincerely,

Edward A. Oxer

EAO/mg

Enclosures

TASK NO. 1

PREDICT TWO HIGH AND TWO LOW SCORING CRITERION GROUPS

Below is a list of possible groups to which this scale could be administered for the purpose of validation. From this list of criterion groups, please select the two groups that would be most identified with citizen participation in community mental health center boards (i.e., those that would score high on the attached attitude scale). Next, please select the two groups that would be least identified or in greatest disagreement with citizen participation in community mental health boards.

1. _____ Two groups most in agreement

2. _____

1. _____ Two groups least in agreement

2. _____

A. elite (high income) CMHC board members
B. middle income CMHC board members
C. low income CMHC board members
D. members of a CMHC policy board
E. members of CMHC advisory board
F. consumer members of a CMHC board
G. provider members of a CMHC board
H. professional staff of a CMHC
I. CMHC directors
J. state hospital staff
K. state hospital directors
L. department of mental health officials
M. NIMH officials
N. county commissioners
O. county government staff
P. social agency staff
Q. social agency directors
R. university faculty
S. high income consumers of CMHC services
T. middle income consumers of CMHC services
U. low income consumers of CMHC services
V. high satisfaction consumers
W. low satisfaction consumers
X. family members of consumers
Y. county (Community mental health board) members
Z. county (Community mental health board) chairpersons
AA. CMHC board chairpersons
BB. county directors
CC. minority group consumers of CMHC services

TASK NO. 2

PREDICT DIRECTIONALITY OF ITEMS --

respond to each of the eighty scale items as per the instructions on the scale indicating, in your opinion, how an individual who was strongly identified (i.e., in high agreement) with citizen participation in CMHC boards would respond.

TASK NO. 3

ESTIMATE CONTENT VALIDITY OF SCALE ITEMS --

suggest different language, new scale items for areas that might have been overlooked, changes in wording, as well as other comments that would help clarify scale items and, hence, the issue under examination.

TASK NO. 4

VALIDATE THE SEVEN FACTORS OF THE SCALE --

categorize each statement in terms of the factors listed below:

CDM - Control over the decision-making process. What different models of decision-making exist among community mental health center boards? On a continuum, they range from full policy-making control to token or non-existent input. Which model reflects an appropriate degree of influence over the CMHC's decision-making process?

RCB - Role of community mental health center's board. Should the role of the board be well defined? Does this help the members perform a more useful function? What are the appropriate functions of the board? How does the board decide what tasks it should perform?

SAM - Selection and appointment of members. How are board members selected? What is the appropriate means of selection? How should board members be appointed?

RB - Representative of board. Who should be represented on the board? What should the scope of membership be in order to have a board which reflects the catchment area population? What should be the relative proportion of professionals, consumers and elite community members represented on the board?

ICP - Impact of citizen participation. What effect does citizen participation have upon the community and the mental health program with which it is associated? Does citizen participation make a difference?

NCP - Need for Citizen Participation. Can relevant community mental health services be provided without citizen participation? Who says citizen participation is necessary?

PC - Participant Characteristics. How energetic and active should participants be who are members of CMHC boards? Are the best members those who are already active in other agency boards? How knowledgeable should participants be about mental health issues?

Please respond to each scale item in terms of the category in which you believe it falls and circle the corresponding initials representing the factor.

Please refer to the examples below for an illustration of how you might indicate your answers:

EXAMPLE 1.

Citizens involved in CMHC boards should not become involved in advocacy in behalf of center clients.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

An individual who wished to categorize this item as related to the role of the CMHC board would circle "RCB."

There may be some items that can't be classified. Please indicate this by placing an "X" to the left of "CDM" in the designated space.

EXAMPLE 2.

Citizen participation in CMHC boards should be the same as consumer control of community mental health services.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

An individual who felt that this item overlapped more than one category with the major factor being control of decision-making would circle "CDM" as the strongest factor and underline no more than two additional factors such as role of community mental health center board "RCB," and/or participant characteristics "PC."

Please proceed to complete Tasks 2, 3 and 4 directly on the attached scale.

A SCALE TO MEASURE ATTITUDES TOWARD CITIZEN PARTICIPATION IN

COMMUNITY MENTAL HEALTH CENTER BOARDS

A number of writers in the field of citizen participation have expressed the feeling that it is the right of all citizens to participate in decision-making matters which affect their lives. Until recently, only the affluent or elite members of our society have had that right. Citizen participation then, is a broad term referring to any citizen of the country expressing their opinion whether consumer or provider of mental health services by participation in a political process. There are many forms of citizen participation or community involvement. The purpose of this research is to determine which form is most appropriate to which community.

Citizen participation means different things to different people. For some, it is the same as consumer control and implies full policy-making control over the major issues affecting the community mental health center programs by those who actually use the services. This seems to be particularly true in communities where the poor or racial and ethnic minorities do not have a "real voice" in the policy determination of many community institutions that affect their lives.

For others, (i.e., the more affluent members of the community) citizen participation means citizen support for community mental health center programs, but in the form of raising funds and matter-of-fact approval of the "professional issues" brought by the staff of the center. Board members often defer to professional judgement and opinion in the majority of cases and show little interest in advocacy in behalf of clients of the program.

Some mental health services, particularly those that are privately operated may be completely governed by professional interests. Although this is less the style with public or private non-profit community mental health centers, many centers do have professional advisory boards mandated by the Community Mental Health Center Amendments of 1975.

This scale seeks to have you express your opinion on the issue of citizen participation. The information you provide will be valuable in helping us to better understand the issue of citizen participation.

Please read each of the statements carefully and for each one indicate to what extent you personally agree or disagree with it. You should do this by circling one of the six choices that best represents your feeling about the statement. You will note that the choices permit you to express an opinion that ranges from strong agreement to strong disagreement.

Circle AAA, if you strongly agree
Circle AA, if you moderately agree
Circle A, if you slightly agree
Circle D, if you slightly disagree
Circle DD, if you moderately disagree
Circle DDD, if you strongly disagree

Please refer to the two examples below for an illustration of how you might indicate your answers:

EXAMPLE 1.

Citizen participation in CMHC boards should be the same as consumer control of community mental health services.

AAA AA A D DD DDD

An individual who wished to indicate agreement, but only slight agreement with this statement, would circle the choice "A."

EXAMPLE 2.

Citizens involved in CMHC boards should not become involved in advocacy in behalf of center clients.

AAA AA A D DD DDD

An individual who wished to indicate a moderate degree of disagreement with this statement would circle the choice "DD."

Make sure that you circle a symbol for each statement. Leave none of the items blank and make only one circle for each item. In some cases, you may feel that you do not know how to judge a statement. When this occurs, please make the best estimate you can. You should not spend more than a few seconds on each item. If it seems difficult to make up your mind, make the best judgement you can and go on to the next item.

Please proceed to the first item.

A SCALE TO MEASURE ATTITUDES TOWARD CITIZEN PARTICIPATION IN COMMUNITY MENTAL HEALTH CENTER BOARDS

1. Citizen representatives should vote on decisions affecting the community mental health center, but their decisions should be able to be reversed by the center's administration.

   AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

2. Community residents who have actually used the services of the center should be represented on the center board.

   AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

3. Citizen representatives involved in community mental health center boards should be consulted about policy decisions before they are made.

   AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

4. In order to participate in making decisions in a community mental health center board, citizens should have extensive knowledge of community mental health service delivery systems.

   AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

5. Citizen representatives should advise in determining the community mental health center's budget.

   AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

6. Citizen representatives should be elected to the community mental health center's board by the residents of the catchment area rather than be appointed by governmental officials.

   AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

7. Citizen participation should involve consumers in making policy decisions for the community mental health center.

   AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

8. A most important area for citizens to be involved is program planning and evaluation of community mental health center services.

   AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

9. New community mental health center programs should not be initiated by citizen members of community mental health center boards as they are not capable of designing programs of this type.

   AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

10. Citizen representatives of community mental health center boards who do not regularly attend meetings should be asked to give up their membership.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

11. Citizen participation would be most effective when the board has less than fifteen members.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

12. Citizen representatives should be involved in the hiring and firing of the community mental health center's director.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

13. Accomplishments of the community mental health center board should be an important factor in evaluating the effectiveness of citizen participation in community mental health services.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

14. Citizen members of community mental health center boards should be selected for their energy level and leadership abilities.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

15. Citizen representatives to community mental health center boards should represent a cross-section of all elements of the catchment area.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

16. Upper middle class members of the community should serve on community mental health center boards to assist in fund raising activities.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

17. Providers of mental health services should be in the majority on community mental health center boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

18. Citizen participation should be an important part of the planning process for community mental health centers.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

19. Citizen representatives should serve on community mental health center's policy making boards instead of advisory boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

20. Citizen representatives should advise in evaluation of the community mental health center's service delivery system.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

21. Citizen representatives of the community should be involved in the day-to-day operation of the community mental health center.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

22. Local business and industry should be represented on community mental health center boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

23. Citizen boards would be a useful addition to the mental health system.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

24. Appointments to all community mental health center boards should be approved by the State mental health authority.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

25. Citizen participation in community mental health center boards would be most effective if the catchment area is a politically viable area such as a county or other governmental unit.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

26. Consumers should be in the majority on community mental health center boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

27. Citizen participation should be most effective when the board meets at least once per month.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

28. Citizen participation should involve community residents in identifying mental health problems that need to be acted on.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

29. Citizen participation should be most effective when the board is appointed by a governmental body.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

30. Citizen representatives should be involved in the setting of community mental health center program priorities.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

31. If local citizens are involved in policy making and decisions, mental health professionals are not likely to be attracted to community mental health centers.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

32. Citizen participation in a private non-profit corporation which administers all community mental health center services in the catchment area would be the most effective form of citizen participation.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

33. Every community mental health center should have consumer/patient representation on the board of the program.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

34. Every community mental health center should have formally associated with it a local citizen's board assigned significant responsibilities.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

35. Citizen representatives should share in making final decisions with those who hold the ultimate power in the community mental health center.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

36. Citizen representatives on advisory boards should have direct input to the governing board rather than through center staff.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

37. Appointments to community mental health center boards should be made primarily by other community agencies.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

38. Citizen participation in the planning and operation of community mental health center programs have not produced sufficient payoff to make it worth our while.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

39. Citizen participation should involve residents in implementing community mental health center programs.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

40. Citizen representatives involved in community mental health center boards should have prior experience with other social agency boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

41. An active volunteer program in the community mental health center would be a more effective mechanism for involving citizens in community mental health center services than having them serve on a board.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

42. Greater citizen participation should help the community mental health center to offer better services to residents of the catchment area.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

43. Citizen representatives involved in community mental health center boards should have delegated power to make decisions.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

44. Citizens who are most active in other social agency boards would make the most effective members of community mental health center boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

45. It should be more effective to have the families of community mental health center patients represented on the board than the patients themselves.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

46. Citizen participation would be most effective if the boards on which they serve have substantial authority and responsibility.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

47. Low income persons are not sophisticated enough to participate in policy making in community mental health center boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

48. Citizen participation in community mental health center boards would have an impact on changing staff attitudes.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

49. Citizen representation in community mental health center boards should be consulted about decisions before they are made.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

50. Greater citizen participation would hinder the working relationship between the community mental health center and other social agencies.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

51. An annual service plan should be prepared by the community mental health center board in conjunction with the residents of the catchment area.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

52. Greater citizen participation in community mental health center boards would hamper staff efficiency.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

53. Citizen representatives involved in a community mental health center board would find the experience a rewarding and gratifying one.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

54. Fund raising should be an important activity for citizens participating in community mental health center boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

55. Citizens would be reluctant to serve on boards of community mental health centers because they don't have the knowledge to make an effective contribution.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

56. Citizen participants should speak for the group which they represent rather than for themselves.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

57. Providers and non-providers of health services should be represented in equal proportion on community mental health center boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

58. An effective group of community representatives serving on the community mental health center board would help to increase the utilization rates of center services.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

59. Citizen participation in community mental health center boards would be a way of training community residents in democratic values.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

60. Citizen participation in a community mental health center board would be most effective if their role is clearly defined.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

61. Citizen representatives involved in community mental health center boards should have full control over policy decisions that they make.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

62. Community mental health center boards should sponsor forums to inform the community about problems of providing services to the area.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

63. Citizen representatives involved in community mental health center boards should receive financial remuneration for their effort.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

64. Citizen participation should be a necessary part of community mental health planning.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

65. Efforts to involve local citizens in community mental health center planning and decision-making will prove to be undemocratic in that a few citizens will participate and those that do will do so for personal ambition or to advance special interests.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

66. Citizen representation in the local mental health association is an effective means of involving community residents in community mental health programs.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

67. Citizens who serve on community mental health center boards should be in agreement with community mental health ideology.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

68. Citizen representatives should be involved in community mental health center boards primarily as a means of educating the public about mental health services.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

69. Staff of the community mental health center should not be involved in the appointment of citizen representatives to the center.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

70. Low income community residents should be involved in community mental health center boards in order to provide therapy to the community as a whole.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

71. Employing community residents as paraprofessionals in the community mental center would be a more effective means of citizen participation than having citizens serve on a community mental health center board.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

72. Militant social action groups should be permitted to participate in the planning of community mental health center services.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

73. Citizen representatives should have a constituency to which they are clearly accountable.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

74. Attending meetings regularly should be an important part of citizen participation in community mental health center boards.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

75. Community representatives should have a complete orientation and training program so that they can participate effectively in the decision making of the community mental health center.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

76. Efforts to involve citizens in mental health programs have not produced sufficient payoff to make them worthwhile.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

77. Consumers of services should be involved in community mental health center decision-making in order to control the cost of mental health care.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

78. Greater citizen participation would bring greater public support to the community mental health center.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

79. Greater citizen participation in community mental health center boards would insure greater representation of the wishes of residents of the catchment area.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

80. Local political leaders should be on the governing board of the community mental health center.

AAA AA A D DD DDD ___ CDM RCB RB SAM ICP NCP PC

APPENDIX B

PILOT: INSTRUCTIONS, 45-ITEM SCALE, SEMANTIC DIFFERENTIAL, CONTROL OVER DECISION-MAKING SCALE, AND DEMOGRAPHIC ITEMS

CITIZEN PARTICIPATION
IN
COMMUNITY MENTAL HEALTH CENTER (CMHC) BOARDS SCALE

It is the right of all people to take part in the every day issues which touch their lives. Citizen participation in mental health is the idea that any citizen can be involved in deciding how mental health services should be run, whether a user of mental health service or a mental health professional, by taking part as a CMHC board member. There are many ways for citizens to participate. The purpose of this study is to find out what you think of citizens taking part in the board of a CMHC.

For a community mental health center (CMHC) to get Federal funds, it must provide a wide range of services.

The CMHC must also have a board that can speak for the mental health needs of the people of the service area.

This scale seeks to have you express your ideas on the issue of citizen participation. The information you give will be valuable in helping us to better understand the issue of citizen participation.

Please read each of the statements carefully and for each one indicate to what extent you agree or disagree with it. You should do this by circling one of the six choices that best states your ideas about the statement. You will note that the choices permit you to express an opinion that ranges from strong agreement to strong disagreement.

Circle AAA, if you strongly agree
Circle AA, if you moderately agree
Circle A, if you slightly agree
Circle D, if you slightly disagree
Circle DD, if you moderately disagree
Circle DDD, if you strongly disagree

Please refer to the two examples below for an illustration of how you might indicate your answers:

EXAMPLE 1.

Citizen participation in CMHC boards should be the same as consumer control of community mental health services.

AAA AA A D DD DDD

An individual who wished to indicate agreement, but only slight agreement with this statement, would circle the choice "A."

EXAMPLE 2.

Citizens involved in CMHC boards should not become involved in advocacy in behalf of center clients.

AAA AA A D DD DDD

An individual who wished to indicate a moderate degree of disagreement with this statement would circle the choice "DD."

Make sure that you circle a symbol for each statement. Leave none of the items blank and make only one circle for each item. In some cases, you may feel that you do not know how to judge a statement. When this occurs, please make the best estimate you can. You should not spend more than a few seconds on each item. If it seems difficult to make up your mind, make the best judgement you can and go on to the next item.

CITIZEN PARTICIPATION IN CMHC BOARDS

1. Citizen board members should vote on issues affecting the CMHC but their choices should be able to be changed by the center's director.

AAA AA A D DD DDD

2. People who have used the center should be represented on the CMHC board.

AAA AA A D DD DDD

3. In order to take part in voting on the CMHC board, citizens should have knowledge of mental health services.

AAA AA A D DD DDD

4. Citizen board members should be elected to the CMHC board by local people rather than be appointed by the county or city.

AAA AA A D DD DDD

5. Citizen members of CMHC boards who do not attend meetings should be asked to resign (leave).

AAA AA A D DD DDD

6. Citizen members of the board should be involved in the hiring and firing of the CMHC director.

AAA AA A D DD DDD

7. What the CMHC board has done (achieved) should be a factor in looking at the results of citizens taking part in CMHC boards.

AAA AA A D DD DDD

8. Citizen members of CMHC boards should be selected for their drive and because they are leaders.

AAA AA A D DD DDD

9. Citizen members of the CMHC board should represent a sample of all parts of the service area.

AAA AA A D DD DDD

10. CMHC boards should be made up of mostly mental health professionals.

AAA AA A D DD DDD

11. Citizen board members should serve on CMHC governing boards instead of advisory boards.

AAA AA A D DD DDD

12. Citizen board members should be involved in the day-to-day workings of the CMHC.

AAA AA A D DD DDD

13. Local businessmen should be asked to be members of CMHC boards.

AAA AA A D DD DDD

14. Those named to CMHC boards should be approved by the State Mental Health Department.

AAA AA A D DD DDD

15. Citizens taking part in CMHC boards would bring the best results if the service area of the center is the same as the county.

AAA AA A D DD DDD

16. People who have used the services should be in the major group on CMHC boards.

AAA AA A D DD DDD

17. Citizen board members would have the most effect when they are appointed by the county.

AAA AA A D DD DDD

18. If local people are involved in policy making, mental health professionals are not likely to want to work in CMHC's.

AAA AA A D DD DDD

19. Citizen board members serving on a private non-profit corporation which runs all CMHC services in the service area would be the most effective form of citizen input.

AAA AA A D DD DDD

20. Every CMHC should have clients serving on the board.

AAA AA A D DD DDD

21. Citizen board members should share in policy making with those who hold the power in the CMHC.

AAA AA A D DD DDD

22. Those named to CMHC boards should be chosen by other agencies.

AAA AA A D DD DDD

23. Citizens sharing in the planning and running of CMHC's have not produced enough payoff to make it worthwhile.

AAA AA A D DD DDD

24. Citizen board members of the CMHC should have had experience on other social agency boards.

AAA AA A D DD DDD

25. A volunteer program would have more effect on involving citizens in the CMHC than having them serve on the board.

AAA AA A D DD DDD

26. Citizen board members should have the power to make decisions such as approving the CMHC budget.

AAA AA A D DD DDD

27. Those who are active on the civic boards should make the most effective members of the CMHC boards.

AAA AA A D DD DDD

28. It should be more effective to have the families of CMHC clients on the board than the clients themselves.

AAA AA A D DD DDD

29. Citizens taking part in CMHC boards would have an impact on changing how staff treats clients.

AAA AA A D DD DDD

30. Greater citizen input would hinder the work between the CMHC and other social agencies.

AAA AA A D DD DDD

31. Greater citizen input in CMHC boards would reduce staff efficiency.

AAA AA A D DD DDD

32. Fund raising should be an important job for citizens taking part in CMHC boards.

AAA AA A D DD DDD

33. Citizen board members should speak for the group which they represent rather than for themselves.

AAA AA A D DD DDD

34. People who speak for clients and people who speak for mental health professionals should serve in equal numbers on CMHC boards.

AAA AA A D DD DDD

35. Those who are good at speaking for the community should serve on the board to help to increase the use of the center.

AAA AA A D DD DDD

36. Having citizens take part in CMHC boards would be a way of training local people in democratic values.

AAA AA A D DD DDD

37. Citizens taking part in CMHC boards would be most effective in their role is clearly defined.

AAA AA A D DD DDD

38. CMHC boards should sponsor forums to inform the public about problems of servicing the area.

AAA AA A D DD DDD

39. Citizens who serve on CMHC boards should agree with community mental health ideas.

AAA AA A D DD DDD

40. Staff of the CMHC should not be involved in the naming of citizens to the board.

AAA AA A D DD DDD

41. Militant social action groups should be allowed to take part in the planning of CMHC services.

AAA AA A D DD DDD

42. Citizen board members should have local groups to which they are accountable.

AAA AA A D DD DDD

43. Greater citizen input would bring greater public support for the CMHC.

AAA AA A D DD DDD

44. Local political leaders should be on the board of the CMHC.

AAA AA A D DD DDD

45. Citizen members of CMHC boards should be asked about policies before they are made.

AAA AA A D DD DDD

INSTRUCTIONS: Rate the following concept with respect to the adjectives listed below. Circle the number that indicates the degree to which one or the other of the terms describes the concept:

Citizen participation in Community Mental Health Boards?

Good	1	2	3	4	5	6	7	Bad
Ineffective	1	2	3	4	5	6	7	Effective
Irrelevant	1	2	3	4	5	6	7	Relevant
Timely	1	2	3	4	5	6	7	Untimely
New	1	2	3	4	5	6	7	Old
Regressive	1	2	3	4	5	6	7	Progressive
Wise	1	2	3	4	5	6	7	Foolish
Simple	1	2	3	4	5	6	7	Complex
Wrong	1	2	3	4	5	6	7	Right
Sophisticated	1	2	3	4	5	6	7	Naive
Narrow	1	2	3	4	5	6	7	Broad
Rash	1	2	3	4	5	6	7	Considered
Realistic	1	2	3	4	5	6	7	Unrealistic
Needed	1	2	3	4	5	6	7	Unneeded
Strong	1	2	3	4	5	6	7	Weak
Unimportant	1	2	3	4	5	6	7	Important
Sterile	1	2	3	4	5	6	7	Fertile
Conflicting	1	2	3	4	5	6	7	Cooperative
Active	1	2	3	4	5	6	7	Passive

CITIZEN PARTICIPATION IN CMHC BOARDS

INSTRUCTIONS: Rate the concept of Citizen Participation in CMHC boards for each board member group. Please rate all three groups in terms of whether they should have high or low control:

Board Member Group	Degree of Control Over Decision Making Process
Health Care Professionals (Provider Members) Those who claim their living from health care	Low 1 2 3 4 5 6 7 High
Elite Members (Business, professional and community leaders interested in mental health).	Low 1 2 3 4 5 6 7 High
Consumer (Client) Members Family members and/or those who have used the CMHC services.	Low 1 2 3 4 5 6 7 High

1. Please indicate your age:

1) Less than 18	4) 30-34	7) 45-49	10) 60-64
2) 19-24	5) 35-39	8) 50-54	11) 65-69
3) 25-29	6) 40-44	9) 55-59	12) 70 and Over

2. Sex: 1) ___ Male 2) ___ Female

3. Marital Status: 1) ___ Married 3) ___ Single
2) ___ Widowed 4) ___ Separated or Divorced

4. Education:
1) ____ Grade School
2) ____ Some High School
3) ____ High School
5) ____ Some College
6) ____ College Graduate
7) ____ Graduate or Professional
Specify: _____

5. Please indicate your Gross Family Income:

1) _____$4,999 or Under
2) _____$5,000-$9,999
3) _____$10,000-$14,999
4) _____$15,000-$19,999
5) $20,000-$29,999

6. Number in Your Family: (Circle one) 1) 1, 2) 2, 3) 3, 4) 4, 5) 5, 6) 6, 7) 7, 8) 8, 9) 9, 10) More than 9.

7. Number of Years in Community:
1) ____ Less than 1 Year
2) ____ 1-5 Years
3) ____ 6-10 Years
4) ____ 11-20 Years
5) ____ 21-30 Years
6) ____ More than 30

8. Please indicate your Racial/Ethnic Background:

   1) ___ Black 2) ___ White

   3) ___ Chicano 4) ___ Other; Specify _____

9. Occupation: 1) ___ Professional 4) ___ Clerical/Office 7) ___ Farming
   2) ___ Skilled Trades 5) ___ Business/Sales 8) ___ Other
   3) ___ Self-employed 6) ___ Managerial Specify: _____

10. Do you currently hold elected office:

    1) ___ County Commissioner 3) ___ State
    2) ___ City/Township 4) ___ Other Specify: _____

11. Have you previously held elected office?

    1) ___ County Commissioner 3) ___ State
    2) ___ City/Township 4) ___ Other Specify: _____

12. Are you employed in health care? 1) Yes 2) No

13. What is your position? Specify: _____

14. If yes, how long? 1) Less than 1 year 4) 6-10 years
    2) 1-3 years 5) 11-20 years

15. Have you used mental health services? 1) Yes 2) No

16. If yes, please indicate kind: 1) CMHC 3) Other
    2) Private Specify: _____

17. How long did you use services? 1) Less than 1 month 4) 1-3 years
    2) 2-6 months 5) 3-5 years
    3) 7-12 months 6) 5 or more years

18. Do you belong to an organized group of
    people who have used mental health services? 1) Yes 2) No

19. If yes, Specify: _____

20. Are you a CMH Board Member: 1) Yes 2) No

21. If yes, please indicate type: 1) PA-258 Board
2) CMHC Governing Board
3) CMHC Advisory Board

22. Are you a Consumer or Provider Member? 1) Consumer 2) Provider

23. How long have you been a board member?

1) Less than 1 year
2) 1-2 years
3) 3-5 years
4) More than 5 years

24. Are you currently the Chairperson of the Board? 1) Yes 2) No

25. Have you previously been the Chairperson? 1) Yes 2) No

26. Are you active in other community boards? 1) Yes 2) No

27. Are you active in other civic activities? 1) Yes 2) No

28. Are you a member of the Mental Health Association in Michigan? 1) Yes 2) No

APPENDIX C

LETTER TO FEDERALLY FUNDED CHMCs

January 15, 1979

Dear

Enclosed is an abstract of my doctoral research on "Citizen Participation in Community Mental Health Center Boards."

Citizen participation has been an area of interest through-out my nine year association with the Ingham Community Mental Health Center especially in the past three years as Center Director. With the advent of P.L. 94-63 and a renewed interest in meaningful citizen participation, I have been especially interested in an expanded knowledge base in the area. The core of my proposal involves the development of a means of measuring attitudes related to Citizen Participation in Community Mental Health Center Boards.

One of the groups that I would like to sample in order to validate the scale is board members of federally-funded Community Mental Health Centers in Michigan. Your cooperation and the participation of your board of directors in this study will be helpful in promoting effective citizen participation in federally-funded centers in Michigan. I plan to make the results available to all participating groups as soon as possible after the completion of the study.

I have been in touch with Dr. Paris Finner, Program Development Specialist of the Detroit-Wayne Community Mental Services Board and she has provided a list of Community Mental Health Centers in Wayne County. I would greatly appreciate it if you could provide a list of your board members' names and addresses so that I might contact them regarding their participation in the study. The study involves completing a questionaire that would require about thirty minutes of their time.

I would be glad to answer any further questions you might have regarding this project. Your support is greatly appreciated.

Sincerely,

Edward A Oxer

Edward A. Oxer, A.C.S.W.
Director
Ingham CMHC

A B S T R A C T

DEVELOPMENT OF A SCALE
TO
MEASURE ATTITUDES TOWARD CITIZEN PARTICIPATION IN CMHC BOARDS

by Edward A. Oxer

Statement of the Problem

The concept of citizen participation has been a central theme in American democracy and politics. Community institutions and agencies, as part of the fabric of American democracy, have naturally been influenced significantly by the underlying philosophical base of community involvement and local control.

Large State mental hospitals that were for many communities the exclusive providers of (inpatient) mental health services in the early 1950's with the impetus of a strengthened mental health policy at the State and Federal levels gave way to the "third revolution" in psychiatry; that of community mental health.

Local communities were to be served by locally operated, community-based mental health services, but the problem of defining the communitys' boundaries and assuring suitable citizen input, representative of the community, was greater than that anticipated by the planners. The controversy soon became polarized around citizen participation versus citizen control. Professional and consumer groups squared off over who would control the nature of the mental health services provided. How should the "community" be defined and who were the "representatives" if the community became the central issues.

Statement of Purpose

The purpose of the study is to expand upon the research done by the Health Policy Advisory Center (Health PAC) entitled, "Evaluation of Community Involvement in CMHC's" (1972). This will be done by developing an instrument to measure the attitude toward citizen participation in CMHC boards, and thereby attempting to establish a method of measuring the attitude toward the most salient variable of the Health PAC study. Ultimately, it is hoped that, via the development of this scale, a means will be found to measure one of the major constructs in a field that abounds with ideological fervor but little in the way of documentation and quantification. Through the development of this instrument, more information and knowledge will be acquired regarding the area of citizen participation, a process which is far from adequately understood. The importance of this study is evident for any

community mental health center program that does not develop a suitable mechanism for insuring adequate community involvement, so as to relate itself to community needs, will soon be suffering from a lack of community support often with financial and political consequences.

Methodology

A series of eighty statements were developed from an extensive review of the citizen participation in mental health literature. Seven factors or subscales were hypothesized and the eighty statements were scaled in the Likert format. Seven experts in the field rated the eighty items and predicted directionality of the items, as well as into which factor the items fell. Items were reviewed for content validity and criterion groups were also selected from an expanded list of groups concerned with citizen participation in community mental health. A total of forty-five items and six factors received sufficient support from the experts to be included in a pilot of the scale. In addition to the forty-five items, a semantic differential, an additional criterion measure relating to board member control of the decision-making process and demographic items were also piloted on staff of a CMH system. The final stage of the instrument development involves the criterion validation in which several groups such as Michigan CMHC board members, CMH services board members, Mental Health Association board members, state hospital directors and consumers of mental health services complete the scale in terms of their view of citizen participation.

Significant correlations are expected between the cumulative scores for each group and the criterion measures, as well as certain of the demographic characteristics. Significant differences are expected between groups, indicating that the scale has the ability to discriminate between those heavily in agreement with those who favor a strong citizen role in CMHC decision-making and those who do not.

APPENDIX D

MAILED QUESTIONNAIRE

Community Mental Health Board

Clinton • Eaton • Ingham

INGHAM COMMUNITY MENTAL HEALTH CENTER

THOMAS M. ENNIS, J.D.
EXECUTIVE DIRECTOR
COMMUNITY MENTAL HEALTH

GILBERT DE BATH, PH.D.
CLINICAL DIRECTOR

March 16, 1979

Dear Participant:

The enclosed questionnaire is concerned with citizen participation in community mental health center boards and is part of a state-wide study that I am conducting in conjunction with my doctoral program at Michigan State University. This study has been approved by the Michigan Department of Mental Health and will provide a basis for assessing attitudes toward citizen participation in community mental health center boards in Michigan.

The results of this study will provide information that will be useful in the selection of community mental health board members, as well as assessing the impact of board member training.

Participation in this study is strictly voluntary and the results will be handled in an anonymous and confidential manner.

I am particularly interested in obtaining your response because your experience with community mental health will contribute significantly to an expanded knowledge base in this increasingly important area.

The enclosed questionnaire has been pretested by people with background similar to yours and it has been revised in order to make it possible to obtain all necessary data while requiring a minimum of your time. The average time required for completing the questionnaire is about thirty minutes.

It would be appreciated if you could complete the questionnaire prior to March 26. Please return the questionnaire directly to me or via my mailbox. Other phases of this study cannot be carried out until analysis of this questionnaire data is complete.

I would welcome any comments that you might have concerning any aspects of citizen participation in community mental health center boards not covered in this questionnaire. I would be pleased to send you a summary of the questionnaire results if you so desire.

Thank you for your cooperation.

Very truly yours,

Edward A. Oxer

Edward A. Oxer, Director
Ingham Community Mental
Health Center

407 W. GREENLAWN LANSING, MICHIGAN 48910 PHONE (517) 374-8000

DO NOT WRITE IN THIS AREA

Your code # is |__|__|__|
1 2 3

4. Please indicate your age:
(0) Less than 19 (4) 35-39 (8) 55-65
(1) 19-24 (5) 40-44 (9) 66 & Over
(2) 25-29 (6) 45-49
(3) 30-34 (7) 50-54

5. Sex and Marital status
(1) Male, married (5) Male, widowed
(2) Female, married (6) Female, widowed
(3) Male, single (7) Male, separated or divorced
(4) Female, single (8) Female, separated or divorced

6. Education:
(1) Grade School (5) Some College
(2) Some High School (6) College Graduate
(3) High School Grad. (7) Graduate or Professional School
(4) Technical School

7. Please indicate your Gross Annual Family Income:
(1) $4,999 or Under (4) $15,000 - $19,999
(2) $5,000 - $9,999 (5) $20,000 - $29,999
(3) $10,000 -$14,999 (6) $30,000 and over

8. Please indicate whether your community is mostly:
(1) Urban (3) Suburban
(2) Rural (4) Mixed

9. Please indicate your Racial/Ethnic background:
(1) Black (3) Chicano
(2) White (4) Other Minority

10. Occupation (select only one that best reflects your work):
(0) Professional (4) Business/Sales (8) Housewife
(1) Skilled Trades (5) Managerial (9) Retired
(2) Self-employed (6) Farming
(3) Clerical/Office (7) Unskilled

11. Do you currently or have you previously held elected office?
(1) County Commissioner (4) Other
(2) City/Township (5) Not held elected office
(3) State

12. Are you employed in health or mental health care?
(1) Clinical Staff - CMHC (Community Mental Health Center)
(2) Administrative Staff - CMHC (Community Mental Health Center)
(3) Clinical Staff - State Hospital
(4) Administrative Staff - State Hospital
(5) Other Health Care
(6) Not employed in health or mental health care

13. Do you serve on a CMHC Board?
(1) PA-258 Board (County Community Mental Health Services Board)
(2) PA-258 Board Chairperson
(3) CMHC Governing Board member
(4) CMHC Governing Board chairperson
(5) CMHC Advisory Board member
(6) CMHC Advisory Board chairperson
(7) Not a CMHC Board member

14. Are you active in community affairs? Please indicate the number of hours spent per month in community boards, church activities, etc.
(1) 1 or less (4) 9-16 (7) Not active
(2) 2-4 (5) 17-24
(3) 5-8 (6) 25 or more

15. Have you used Mental Health services personally as a client?
(1) CMHC (Community Mental Health Center)
(2) Private
(3) No use of mental health services
(4) CMHC and private

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1. ○○○○○○○○○○
2. ○○○○○○○○○○
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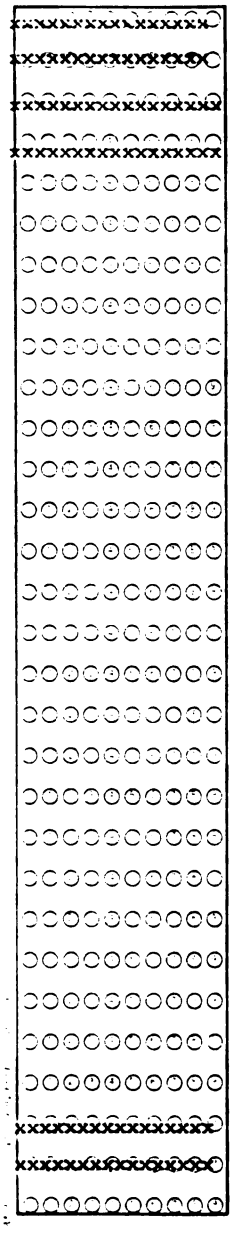
14. ○○○○○○○○○○
15. ○○○○○○○○○○

DO NOT WRITE IN THIS AREA



Scoring Key:

Mark (1), if you completely agree
Mark (2), if you strongly agree
Mark (3), if you moderately agree
Mark (4), if you slightly agree
Mark (5), if you slightly disagree
Mark (6), if you moderately disagree
Mark (7), if you strongly disagree
Mark (8), if you completely disagree

16. Citizen board members should vote on issues affecting the CMHC but their choices should be able to be changed by the center's director.

17. People who have used the center should be represented on the CMHC board.

18. In order to take part in voting on the CMHC board, citizens should have knowledge of mental health services.

19. Citizen board members should be elected to the CMHC board by local people rather than be appointed by the county or city.

20. Citizen members of CMHC boards who do not attend meetings should be asked to resign.

21. Citizen members of the board should be involved in the hiring and firing of the CMHC director.

22. What the CMHC board has accomplished should be a factor in looking at the results of citizens taking part in CMHC boards.

23. Citizen members of CMHC boards should be selected for their drive and because they are leaders.

24. Citizen members of the CMHC board should represent a sample of all parts of the area served by the program.

25. CMHC boards should be made up of mostly mental health professionals.

26. Citizen board members should serve on CMHC governing boards instead of advisory boards.

27. Citizen board members should be involved in the day-to-day workings of the CMHC.

28. Local businessmen should be asked to be members of CMHC boards.

29. Those named to CMHC boards should be approved by the State Mental Health Department.

30. Citizens taking part in CMHC boards would bring the best results if the service area of the center is the same as the county.

31. People who have used the services should be in the major group on CMHC boards.

32. Citizen board members would have the most effect when they are appointed by the county.

33. If citizen board members are involved in policy making, mental health professionals are not likely to want to work in CMHC's.

34. Every CMHC should have persons serving on the board who have used the services.

35. Citizen board members should share in policy making with those who hold the power in the CMHC.

36. Those named to CMHC boards should be chosen by other agencies.

37. Citizens sharing in the planning and running of CMHC's have not produced enough payoff to make it worthwhile.

38. Citizen board members of the CMHC should have had experience on other social agency boards.

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DO NOT WRITE IN THIS AREA

Your code # is |__|__|__|
1 2 3

Scoring Key:

Mark (1), if you completely agree
Mark (2), if you strongly agree
Mark (3), if you moderately agree
Mark (4), if you slightly agree
Mark (5), if you slightly disagree
Mark (6), if you moderately disagree
Mark (7), if you strongly disagree
Mark (8), if you completely disagree

39. A volunteer program would have more effect on involving citizens in the CMHC than having them serve on the board. 39.

40. Citizen board members should have the power to make decisions such as approving the CMHC budget. 40.

41. Those who are active on other civic boards should make the most effective members of the CMHC boards. 41.

42. It would be more effective to have the families of CMHC clients on the board than the clients themselves. 42.

43. Citizens taking part in CMHC boards would have an impact on changing how staff treats clients. 43.

44. Greater citizen input would hinder the work between the CMHC and other social agencies. 44.

45. Greater citizen input in CMHC boards would reduce staff efficiency. 45.

46. Fund raising should be an important job for citizens taking part in CMHC boards. 46.

47. Citizen board members should speak for the group which they represent rather than for themselves. 47.

48. People who speak for clients and people who speak for mental health professionals should serve in equal numbers on CMHC boards. 48.

49. Those who are good at speaking for the community should serve on the board to help to increase the use of the center. 49.

50. Having citizens take part in CMHC boards would be a way of training local people in democratic values. 50.

51. Citizens taking part in CMHC boards would be most effective if their role is clearly defined. 51.

52. CMHC boards should sponsor forums to inform the public about problems of servicing the area. 52.

53. Citizens who serve on CMHC boards should agree with community mental health ideas. 53.

54. Staff of the CMHC should not be involved in the naming of citizens to the board. 54.

55. Militant social action groups should be allowed to take part in the planning of CMHC services. 55.

56. Citizen board members should have local groups to which they are accountable. 56.

57. Greater citizen input would bring greater public support for the CMHC. 57.

58. Local political leaders should be on the board of the CMHC. 58.

59. Citizen members of CMHC boards should be asked about policies before they are made. 59.

60. Citizen board members serving on a private non-profit corporation which runs all CMHC services in the service area would be the most effective form of citizen input. 60.

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INSTRUCTIONS: Judge the following idea by using the adjectives listed below. Mark the number in the circle on the left side of the page that shows the degree to which one or the other of the words describes the idea. Be sure to mark your answer on the circles on the left side of the page.

Citizen Participation in CMHC Boards is:

		Extremely	Very	Slightly	Neutral	Slightly	Very	Extremely	
61.	Good	1	2	3	4	5	6	7	Bad
62.	Ineffective	1	2	3	4	5	6	7	Effective
63.	Irrelevant	1	2	3	4	5	6	7	Relevant
64.	Timely	1	2	3	4	5	6	7	Untimely
65.	New	1	2	3	4	5	6	7	Old
66.	Regressive	1	2	3	4	5	6	7	Progressive
67.	Wise	1	2	3	4	5	6	7	Foolish
68.	Simple	1	2	3	4	5	6	7	Complex
69.	Wrong	1	2	3	4	5	6	7	Right
70.	Narrow	1	2	3	4	5	6	7	Broad
71.	Needed	1	2	3	4	5	6	7	Unneeded
72.	Strong	1	2	3	4	5	6	7	Weak
73.	Unimportant	1	2	3	4	5	6	7	Important
74.	Conflicting	1	2	3	4	5	6	7	Cooperative
75.	Active	1	2	3	4	5	6	7	Passive

INSTRUCTIONS: Judge the idea of Citizen Participation in CMHC boards for each board member group. Please mark the number in the circle on the left side of the page that shows whether you think they should have high or low control. Be sure to mark your answers in the circles on the left side of the page.

	Board Member Group	Degree of Control Over Decision Making Process
76.	Health or Mental Health Professionals (those who claim their living from health or mental health care).	Low 1 2 3 4 5 6 7 High
77.	Business, professional, political and community leaders interested in mental health.	Low 1 2 3 4 5 6 7 High
78.	Those who have used CMHC services and/or their family members (actual clients).	Low 1 2 3 4 5 6 7 High
79.	Low income and/or ethnic, racial minorities who live in the service area (potential clients).	Low 1 2 3 4 5 6 7 High
80.	Entire CMHC Board.	Low 1 2 3 4 5 6 7 High

Thank you for your participation in this study. Please return completed questionnaire to:

Edward A. Oxer
1333 Red Leaf Lane
East Lansing, Michigan 48823

APPENDIX E

FOLLOWUP REMINDER POST CARD

March, 1979

Dear Participant:

I recently mailed a questionaire to you regarding citizen participation in community mental health center boards. I would like to thank those who have responded for your participation, as the success of this important study is highly dependent upon your individual contribution.

If you had intended to respond but have not had the time to complete the questionaire, I would appreciate your doing so at your earliest convenience.

Sincerely,

Edward A Cox

Director
Ingham Community Mental Health Center

APPENDIX F

LETTERS OF APPROVAL

WILLIAM G. MILLIKEN, Governor

V. A. STEHMAN, M.D.,
Acting Director

STATE OF MICHIGAN
DEPARTMENT OF MENTAL HEALTH
LEWIS CASS BUILDING, LANSING MICHIGAN 48926

March 7, 1979

Edward A. Oxer, A.C.S.W.
Director
Community Mental Health Board
300 N. Washington Square
Community Services Center
Suite 401
Lansing, MI 48933

Dear Mr. Oxer:

We have reviewed your proposed dissertation research, "Development of a Scale to Measure the Attitude Toward Citizen Participation in Community Health Boards". We understand that this research involves a client sample who will participate on a voluntary basis. Confidentiality will be maintained and there will be no risk to clients. You have the approval of the Department to proceed with this research, providing that the following is assured:

(1) Approval from the Clinton-Eaton-Ingham Community Mental Health Board.
(2) The questionnaire should have a cover letter indicating that responses are anonymous and confidential, that completing the survey is voluntary, and does not affect services received as a client of the agency.

You might also consider indicating to patients and subjects what use may be made of the data, that the purpose of this questionnaire is for your dissertation research, and whether or not results will be sent back to participants.

Please direct the materials requested and/or any questions to Carol T. Mowbray, Ph.D. (517-373-2746).

Departmental Administrative Procedures are that you provide the Department and the CMH Board with a report of the results of your research. We look forward to being informed of the findings of this interesting study.

Sincerely,

V.A. Stehman, M.D.

CC: Thomas Ennis, Director,
CEI BOARD
Joe Farrell

MICHIGAN THE GREAT LAKE STATE

VAS:CTM:g

COMMUNITY MENTAL HEALTH BOARD
CLINTON-EATON-INGHAM

MEMO

To: Ed Oxer, A,C.S.W., Director
Ingham CMHC
From: Gilbert W. DeRath, Ph.D
Director of Clinical Services
Re: Research Proposal

Date: March 7, 1979

Ed,

I have reviewed your proposal for the "Development of a Scale to Measure Attitudes Toward Citizen Participation in Community Mental Health Center Boards." I approve of implementation of the research within our programs. I assume that you will develop an informed consent format for use with CMH clients.

Attached is the DMH policy on Approval of Research Policies, for your information.

Atch

jlz

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BIBLIOGRAPHY

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