Effective Citizen Participation in Mental Health: Comparative Case Studies

ROBERT A. DORWART, MD, MPH
WILLIAM R. MEYERS, PhD
EDWARD C. NORMAN, MD, MPH

CITIZEN PARTICIPATION has been a prominent but controversial requirement of many federally mandated programs, such as community action program boards, model cities boards, community mental health center catchment area boards, comprehensive health planning boards, and health systems agency boards (*1–5*). Renewed public interest in citizen participation in mental health has been created by the President's Commission on Mental Health (*6*). Public hearings and professional task forces punctuate a national debate about future directions of governmental, professional, and citizen involvement in providing community mental health services.

Treatment of patients has shifted from the confines of mental hospitals to community-based treatment facilities, such as halfway houses, cooperative residences, and ambulatory outpatient clinics in community mental health centers. If these decentralized programs are to succeed, local citizens must actively support and participate in the community mental health services projects.

Dr. Dorwart is a resident in the Harvard Medical School, Department of Psychiatry at the Cambridge Hospital, Cambridge, Mass. Dr. Meyers is professor, Department of Psychology, University of Cincinnati. Dr. Norman is professor and director of the Mental Health Section, Tulane School of Public Health and Tropical Medicine, New Orleans, La.

This study was funded in part by NIMH Grant No. R01 MH 15446–02.

Tearsheet requests to Robert A. Dorwart, MD, Cambridge Hospital, 1493 Cambridge St., Cambridge, Mass. 02139.

We carried out interdisciplinary research on citizen participation in mental health in Massachusetts, using multiple methods of evaluation, and we proceeded in stages to analyze the activities of community mental health catchment area boards. In this report, we present comparative case studies of two mental health catchment area boards in Massachusetts and the reasons for their success or failure.

Background

The history of legislative action establishing the mental health and mental retardation area board system in Massachusetts parallels national developments in legislated citizen participation and in community mental health. In 1963, following a mandate from President John F. Kennedy, Congress enacted the Community Mental Health Centers Act (*7*). Each participating State was required to develop a system, following specific guidelines, for providing comprehensive community mental health services. New elements in planning for community mental health programs were stimulated by this Federal legislation. In Massachusetts, the statewide mental health system was reorganized, and citizen participation through catchment area boards within local area programs was included. The Massachusetts mental health planning project, established by a Federal grant, included a system of regional and area community mental health programs that provided for citizen participation on catchment area boards. To understand the area board system, it is necessary to examine the

background of the legislation that created the boards as well as the law itself.

Viewed in historical perspective, the formal organization of the area boards may be seen as an extension of earlier forms of citizen participation in local mental health programs in Massachusetts, especially the system of mental health association children's clinic boards. The previously established mental health department had constitutional restrictions on the use and the control of public funds in the State. A legal requirement for centralized fiscal control of all State-funded facilities and programs in Massachusetts hampered the establishment of autonomous regional or local programs. In particular, the delegation of budgetary and direct administrative authority to appointed citizen boards was not included in the Massachusetts Community Mental Health Act of 1966, which provided for 37 citizen area boards (*8*). Independent local control emerged as a major issue in the legislative history of the boards. Disagreement was evident, not only over legal and jurisdictional authority, but also over issues of competence and propriety of citizen involvement in policy setting and decision making. After much debate, the conflict over citizen control was resolved in favor of advisory responsibility rather than operational authority for the boards.

Area Boards' Legal Duties and Powers

The general legal powers and duties of the area boards, enumerated in Chapter 735, Section 16, of the General Laws of Massachusetts, include the following:

1. To act as the representative of the citizens of the area.
2. To advise regarding local needs and resources in the development of comprehensive mental health and retardation services.
3. To advise in the recruitment and selection of the area director and associate area director to be appointed by the commissioner.
4. To review and approve the annual plan for the area and to review and make recommendations concerning the annual budget for comprehensive mental health and retardation services for the area.
5. To review arrangements and contracts for programs and services which are a part of the program of the area but which are not conducted within Commonwealth-operated facilities.
6. To consult with the Commissioner in personnel recruitment and appointment policies, in the establishment of program priorities for the area, in reviewing policies regarding relationships with other agencies and organizations.
7. To communicate with the Governor's Mental Health Advisory Council to discuss any matters concerning the area program.
8. To receive funds under contracts or other agreements for community sources, including municipalities or private agencies to provide cooperative or complementary services.
9. To hold regular meetings in each year and to convene special meetings on the call of the president, or 10 members of the board, or the area director, or the Regional Mental Health Administrator, and to elect from the members annually a president and such other officers as deemed appropriate.
10. Additional administrative guidelines for the area boards regarding bylaws, selection, and representativeness and general operating procedures are to be developed by the task force on reorganizing the department of mental health, appointed by the Governor, and approved separately by each Board.

Accomplishment Factors

The first step in our research was to measure the accomplishments of each of the 37 mental health catch-

ment area boards in Massachusetts (*9*). We used factor analysis for the data on all 37 boards. The four major factors, each representing a type or strategy of accomplishment among the boards in Massachusetts, and the subset of variables that best represent each factor were, in summary, as follows:

Accomplishment factor 1: Service creation or improvement

1. The total number of services the board was involved in creating or improving, weighted for the degree of importance of the service and by the stage of operation of the service
2. Average degree of involvement of the area board in service-oriented activities, weighted for importance of the service.

Accomplishment factor 2: Mobilization of outside resources

1. Amount of money obtained by the board from State government
2. Amount of money obtained by the board from Federal Government
3. Concertedness and persistent followthrough of area board's attempts to gain support from the Governor, the legislature, and the commissioner of mental health
4. Frequency and extent of contact by the board with the State Office for Administration and Finance.

Accomplishment factor 3: Local autonomy

1. Amount of money raised by the board from within its area, including private contributions, local community tax funds, and so forth
2. Tendency of area board to review the budgets of health care institutions in its area such as State mental hospitals, local publicly or privately supported clinics, and so forth
3. Contribution to annual plan for the area
4. Area board develops privately incorporated subgroups.

Accomplishment factor 4: Coordination

The total number of contacts by area board with service institutions weighted for the extent of contact; measures the board's efforts to attain more extensive, efficient, and effective collaboration with and among the social service agencies and organizations in its area.

Each type of accomplishment represents a different solution to the common problem of what a board should do. Thus, some boards used political pressure to raise funds from public agencies; some concentrated on encouraging more integrated collaboration among social agencies, while others demonstrated a preference for long-range local planning. In later studies, we found that different characteristics of board members were related to different types of accomplishments (*10*). In additional research, we found that the four kinds of accomplishments were also related to the social ecology of the areas represented by the boards (*11*). Yet, the presence of both active and inactive boards suggested the need for case studies to better understand the dynamics that lead to effective versus ineffective area board activity.

Selection of Cases

We selected two boards for case studies. One board was considered by its members and by the community to be outstandingly successful, and it had attracted some national attention for its community programs. The other board was thought by its members to be unsuccessful, and on our factor scores it was the least active of the 37 boards studied. We focused the studies on (*a*) board member selection and board composition, (*b*) leadership and organization within the boards, (*c*) expectations of members about the board's role, and (*d*) board relationships with other community groups and institutions.

The highly active board, in area A, was the highest ranking in the State for outside resource mobilization and 5th of 37 in service creation; it also ranked above the median for local autonomy and coordination. The ineffective board in area B ranked last on outside resource mobilization and coordination, 35th on local autonomy, and 33d on service creation or improvement.

A comparison of the major accomplishments of the two boards is revealing. In the 3 years preceding the study, board A had obtained a large Federal-State staffing grant to expand programs at the city hospital, obtained a State grant for site location for a community mental health center, and raised money for a halfway house for alcoholics. During the same period, board B had helped a group of local students find space for a halfway house, held a discussion on community needs at the local clinic, and endorsed requests by other groups for new services in the area.

Also important for the case studies was the two areas' differences in social ecology. Area A comprises two highly urbanized towns near metropolitan Boston, each having a population of about 100,000. One town is more densely populated, has a dearth of industry and large businesses, and has a shortage of health care

facilities. The other town is more heterogeneous, including well-to-do neighborhoods and a large minority population. This town has a stronger industrial and commercial base, ties with local universities, and more accessible medical care. In general, area A has a number of special mental health problems that include a sizable alcoholic population, considerable drug abuse, and a relatively high proportion of aged persons.

Area A has few public adult or child psychiatric facilities, and patients are often sent to a State hospital several miles away or to a small, general hospital inpatient unit in the area. Other services are provided by the mental health association clinics and the community mental health center. Area B, on the other hand, comprises four small towns in a rural area with a total population of about 65,000. Two of the towns are considerably larger than the others, and they had a history of competition in many phases of politics between them. Although areas A and B are about equal in median income, area B is more homogeneous socioeconomically, less densely populated, and located far from any large urban center. In contrast to area A, most of the services for area B were located in a nearby State hospital.

Study Method

The area boards were created in 1967, and the interviewing period for this study was 1970–72. We used a historical-qualitative approach, as recommended by Weiss and Rein for evaluating broad-aim programs (*12*). The frame of reference for the research was based in part on the views of the participants (*13*). Accordingly, we chose a case study method that relies on interviews with key informants. The interviewers worked in tandem: one conducted the interviews and the other took notes; 10 interviews were conducted in each area. Key persons in comparable positions in each area were included. The interviewers also attended at least six meetings of each board, visited community facilities, and reviewed archival data, such as the minutes of past board meetings, grant proposals, budgets, and annual plans. The interviewers had been members of a research team that had studied the boards for more than a year.

Recruitment of Members

The original 21 area board members in each catchment area were selected by the commissioner of mental health from a list of nominees compiled by a local citizens' committee (*14*). Subsequently, the boards were to become almost self-perpetuating since they would submit names of persons to replace those whose terms had expired.

In area B, the president of the local mental health association initially recruited board members. His belief that the boards were intended to educate the members about mental health needs in the community led to recruitment from a broad range of community groups, including churches, the United Fund, local lawyers, and teachers groups. This belief in an educational purpose explains the emphasis on diversity and the lack of attention to selecting members who could plan, raise money, influence legislation, create new services, or coordinate existing services. The president believed that any citizen interested in mental health should be a candidate for board membership. However, despite his expressed desire to include representatives from all four towns in the area, the board membership was heavily weighted toward one of the towns. A desire for diversity did not create a geographically representative board.

In area A, recruitment differed from area B in three ways: (*a*) a large nominating committee participated in the initial selection process; (*b*) local professionals were involved in selecting the board and later becoming board members because education was not perceived as the major goal of the board; and (*c*) representatives of politically powerful interest groups were deliberately included. These recruitment differences flowed from different beliefs about the proper function and potential power of the board. In area A, the aim was to constitute a highly knowledgeable board that would be responsive to the community and politically effective. Particularly, the selection of area A members was defined in terms of the local political situation. As in area B, members were recruited from church groups, local lawyers, schools, clinics, and the voluntary mental health and retardation associations. In addition, other persons were included in area A's recruitment, such as hospital administrators, community service agency representatives, university representatives, judges, former legislators, and people known to be associated with mayors in their areas.

A special effort was made to obtain equal representation from the two major towns because of their political competitiveness. The nominating committee ensured that of the 21 members of the board, one town had 11 and the other 10, even though members were more difficult to recruit in one. The president of the board in area A expressed in his philosophy:

> "A staffing grant was being discussed as a possibility before the area board was legislated in 1966 and so we had to get people on the board who could and would work for a grant.

. . . An attempt was also made at this stage to balance mental health and mental retardation interests by inviting the Association for Retarded Children to suggest people to represent retardation issues on the board. I was then chairman of the hospital committee in town so you can't exactly say I was a novice in the field."

The strategy in area A was to select experts for the board rather than persons who would need to be educated about mental health. The area A board also drew on the local university's mental health specialists for technical assistance and for political support.

The importance of planning and incorporating political, legislative, and professional experience into the board's membership was anticipated in area A but not in area B, as underscored by the comment of the president from area B:

"I didn't want to be president anyway, I was president of the Jaycees. And so I knew what it involved. I had no intention of doing it, but they talked me into being vice-president. I underestimated the president—he resigned! And so now I'm president."

Board Organization and Internal Functioning

Board B had intense feelings of role ambiguity. Moreover, there was a lack of followup on projects, partly because of a lack of knowledge about obtaining needed information and following through with sustained action, as depicted in this observation by the board president:

"We submitted specific things to the regional administrator which the Association for Retarded Children and the Mental Health Association asked for—payblocks mostly. It's really hard to say what happened. The mental health group allotments increased, but I don't really know how. We have limited information on how these things get accomplished. Would the regional office of the department of mental health be doing anything different without the area boards?"

From the board president's comments and from our observations of board meetings a feeling of powerlessness, reluctance to act, and ambiguity over the board's proper role was evident. These tendencies toward inaction are illustrated by an observer's notes of board B's meetings:

During one board meeting a member noted that a halfway house needed more money. His plea was answered by the board president: "Money may be the immediate need, but the halfway house needs more discussion, leading to an understanding of the directions it will take and how it will be able to function more effectively and how the area board can be of help." No further action was taken by the board. Although one board member said that the United Fund should contribute to the halfway house, nobody suggested trying to sway the United Fund. The Board endorsed the idea of providing a psychiatric unit at the local general hospital; however, they did not offer to aid in obtaining funds or to carry the request to the department of mental health or State officials. On another occasion, a teacher of the special education class in the area B elementary school gave an informative presentation to the board, but nobody commented on the plea for the area board to do something about the long waiting list for the class. Members appeared to ask questions in order to educate themselves rather than to seek solutions to problems.

In summary, board B's members did not understand their role and felt self-doubt, powerlessness, and vagueness in analyzing problems. Moreover, the board had poor followup, lack of response to stated requests for help, and lack of initiative in perceiving and acting on implied needs. The board's conception of its role as one of self-education explains some of its lack of action orientation. The role ambiguity promoted feelings of powerlessness and lack of action. Statements by board members expressing doubt concerning the board's role were coupled with statements expressing reluctance to act. Ambiguity in the initial legislation also fostered the passive role definition of the board—self-education of board members.

In contrast, board A differed from board B in its demonstrated self-confidence and goal-directedness. Doubt about the proper role of the board was seldom expressed by board A members who seemed to know what they were to do and proceeded efficiently. Speakers at meetings were knowledgeable and seemed competent; they had worked together outside the area board meetings and saw no reason why they should not work smoothly within the area board structure.

Board A's members were service-oriented; discussions at meetings centered on present and future services. Many members were professionals, and almost all had some prior knowledge about mental health. Events at one meeting illustrate the business-like mode of proceedings:

There was discussion of the drug funding applications. The president suggested that "under menacing deadlines" (about a week) the area director, himself and the chairperson of the drug committee be given the power to decide on the applications. He held that there was not time to consult the entire board on the matter. He said: "We may displease the Mayor by taking this thing on, but, if we want a voice in the decision we'll have to take it. We can't just send him a list of six proposals and say OK to all of them—we have to make some judgments as to our priorities. We'll have to think about what they're doing, whether they can get funded elsewhere, and so forth."

This excerpt from the minutes indicates self-confidence, goal-directedness, service orientation, and a

tendency to seize the initiative. It also indicates managerial skills—the ability to organize people, analyze and set priorities, and make a decision under time constraints. A later excerpt illustrates followup:

At a later meeting the president reported on the drug applications. The subcommittee had visited some of the programs on-site and talked with various people connected with the programs. The report had to be in the next day so members were asked to give any additional comments then or to call by nine o'clock the next morning. There was little discussion at this point. It was clear that the members trusted the other members in leadership positions to make a reasonable decision—one that the board could accept.

Board A's heavy reliance on its seven committees constitutes a clear delegation of authority—mental health, mental retardation, alcoholism, legislative, children's service, legal medicine, and site. Each committee reports at meetings and recommends or requests action by the board. The board's committee chairpersons are considered experts, and their opinions are sought by the group. The president attends almost all committee meetings, and he is prepared to discuss the committee reports. The president of board A spent an average of 15 hours a week on board matters, compared to 5 hours for board B's president. This form of committee organization is possible if the president spends the necessary time and if other board members understand the subfields. One result is less reliance on outside professional authority:

Several medical and mental health professionals who are not board members take an active part in the meetings. Their expertise is respected, but they do not make decisions. The members feel they know what is needed and that they are a necessary ingredient in getting facilities and services for the area. The self-confidence of the members allows them to stand up and question the professionals. The latter seem to appreciate the members of the area board for what they can do and have done for the area's program.

Board A is oriented toward political lobbying to obtain services and funding. Its activity and persistence are noted in comments by (*a*) a department of mental health administrator and (*b*) a board member:

(*a*) If the board is carrying its own weight, it calls the turns. There is a problem of boards and professionals; bureaucracy is very defeating. The department does not know what they mean by community mental health; it is such a fragmented philosophy and the department doesn't provide leadership. There is a lot of potential for boards, a lot of different potentials, but right now I would say that political pressure is the biggest potential. Boards should work as a genuine ombudsman if they are operating properly.

(*b*) The board held educational meetings for legislators and followed the budget right through to executive committees. We have one senator on ways and means and we worked with him and followed it right into administration and finance where we had to fight for a compromise. The doctors had the know-how and nurtured it, and husbanded it, and insisted on it every step of the way as we know you have to do if you want to get anything. We did this as a lobbying group. Other boards must not see the value of the area board as a lobbying group. We have pressured not in a general way, but for specific issues.

Local Mental Health Association Relationships

In area A, the local mental health association (MHA) played an important part in the founding and operation of the board. A close working relationship continued. Board A was seen by the local MHA as a means to achieve one of its major goals—obtaining funding for a comprehensive community mental health program. Consequently, the first president of board A was a former MHA president. In area B, the MHA activities were mainly educational. The area board expressed interest in new mental health programs, but, like the local MHA, seldom followed through with any specific proposals or actions. Rather, the members stressed the need to educate themselves about current issues.

In area B, the board emulated the passivity of the local MHA, while in area A the board sought to bring to fruition the MHA's activism. Our findings therefore indicate that local MHAs provided a role model for catchment area boards, rather than competition. From our observations, if the MHA was aggressive, so was the catchment area board; if the local MHA was passive, so was the area board.

State Hospital Relationships

Board A made systematic efforts to establish working relationships with the State hospital and the community general hospital. Written agreements were negotiated among the three parties which established many of the elements of the comprehensive mental health services in the immediate area, rather than at the distant State hospital. In area A, the usual tense relations between catchment area board members, local professionals, and the local State hospital were muted because the hospital was located outside the community.

Area B contained a State hospital. The State hospital staff was hostile toward outsiders, including the board members. The hostility could be traced to activities of a State legislative committee that had earlier investigated conditions at the hospital. Some of the board members had been involved in this investigation and the hospital officials felt threatened. Several other mental hospitals in the State have been under investigation at various times. We found that where such inves-

tigations were demanded by the local citizens, relations between the hospital administration and the local catchment boards were tense. Even in areas not investigated or where a State hospital served several catchment areas, relationships were strained. Catchment area boards were viewed as adversaries espousing a community mental health philosophy that included deinstitutionalization.

Conclusion

The findings from our comparative case studies indicate the importance of the background of the board, its membership composition, its network of relationships in the community, and perhaps most important, its legislated or spontaneously developed sense of purpose or mission.

The legislative history of the boards indicates that community control in direct program decisionmaking authority for boards was not intended. The powers and duties of the area boards were extremely general and open to widely differing interpretations. To many citizen board members, the law was unclear and difficult to translate into action (*15*).

We found that a private, local mental health association that is action oriented is helpful to an area board, both as a role model and as a source of experienced members. A local mental health association that takes a purely educational role is a negative role model.

A State mental hospital in a catchment area can suppress board initiative, because the board tends to rely heavily on the leaden authority of the State hospital. The State hospital rarely has the best community mental health administrators, ordinarily does have political power, and is usually suspicious of the board. Our study raises the question of whether boards of trustees for State mental hospitals have outlived their usefulness. Perhaps hospital boards should be abolished and areawide citizen boards be empowered to function as hospital boards. This authority would minimize the polarization between custodial mental hospital service and dispersed community mental health services; it would require the area board to confront the problem of continuity of care for the chronic mentally ill. In any event, the citizens board should have the power to contract for services within its area—it should be allowed to function as a corporation when necessary to carry out its business.

We found that the greatest impediment to an effective catchment area board was ambiguity about its proper role, a situation that fostered a feeling that it is not legitimate to take an activist role. One determinant of high-role ambiguity and self-doubt appeared to be lack of expert members on the board. Another was lack of clarity and specificity in the law.

Boards that were unsure what they should do or which lacked expertise among their members were paralyzed by feelings of role ambiguity. Other boards with more expert members seized the initiative despite an ambiguous situation. In our opinion, board accomplishment would be fostered by clearer legislative intent concerning citizen participation and by more specific administrative guidelines for board composition, responsibilities, and roles (*16*).

References

1. Vaneko, J.: Community mobilization and institutional change: the influence of the community action program in large cities. Soc Sci Q 609–630, December 1969.
2. Kaplan, M., Gans, H., and Kahn, A.: The Model Cities program: The planning process in Atlanta, Seattle, and Dayton. Praeger, New York, 1970.
3. Kupst, M. J., Reidda, P., and McGee, T. F.: Community mental health boards: a comparison of their development, functions, and powers by board members and mental health center staff. Community Ment Health J 11: 249–256, fall 1975.
4. Roseman, C.: Problems and prospects for comprehensive health planning. Am J Public Health 62: 16–18, January 1972.
5. Health Planning: A special section. Public Health Rep 91: 3–76, January–February 1976.
6. Report to the President from the President's Commission on Mental Health. U.S. Government Printing Office, Washington, D.C., 1978, Vol. 1.
7. Community Mental Health Centers Act. Federal Register, May 6, 1964.
8. Acts, Extra Session. The Commonwealth of Massachusetts. Ch. 735, Boston, 1966.
9. Meyers, W. R., et al.: Methods of measuring citizen board accomplishment in mental health and retardation. Community Ment Health J 8: 313–320, November 1972.
10. Meyers, W. R., Dorwart, R. A., Kline, D. K., and Htucheson, B. R.: Organizational and attitudinal correlates of citizen board accomplishment in mental health and retardation. Community Ment Health J 10: 192–197 (1974).
11. Meyers, W. R., Dorwart, R. A., and Kline, D.: Social ecology and citizen boards: A problem for planners. Am Institute J 43: 169–177 (1977).
12. Weiss, R. A., and Rein, M.: The evaluation of broad-aim programs: Experimental design, its difficulties and an alternative. Admin Sci Q 15: 97–109, March 1970.
13. Dexter, L. A.: Elite and specialized interviewing. Northwestern University Press, Evanston, Ill., 1970.
14. Greenblatt, M.: Psychopolitics. Grune & Stratton, New York, 1978.
15. MacMurray, V. D., et al.: Citizen evaluation of mental health services: An action approach to accountability. Human Sciences Press, New York, 1976.
16. Langton, S.: Citizen participation in America. D. C. Heath and Co., Lexington, Mass., 1978.