Title

The ideology of the mental health professional as a factor in the community service to the chronic mentally ill adult

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THE IDEOLOGY OF THE MENTAL HEALTH PROFESSIONAL AS A FACTOR IN THE COMMUNITY SERVICE TO THE CHRONIC MENTALLY ILL ADULT

by

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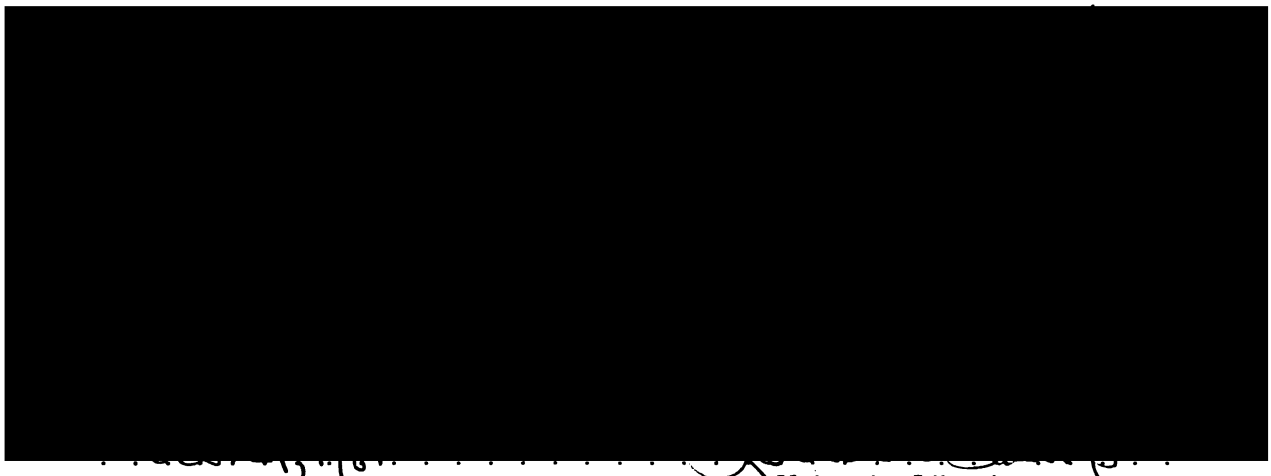

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Abstract

This exploratory study examined the community service to the chronic mentally ill adult population by investigating the adherence to community mental health ideology and the role (specialist or generalist) of a sample (N=34) of mental health professionals. The subjects were obtained from two different community settings, a community mental health center and a special center exclusively for chronic patients. The subjects were administered the Baker-Schulberg CMHI Scale and a scale measurement of community treatment developed by the investigator. T-test and Pearson r correlation co-efficient statistics were utilized to analyze the data. The findings showed that all subjects adhered strongly to community mental health ideology and role or setting had no influence.

Dedication

This project is dedicated to

GILBERT MADRID

for his love, support, and patience.

Acknowledgements

I would like to thank the people who aided in the completion of this research project. Dr. Patricia R. Underwood, my thesis committee chair, provided continuous assistance from the conceptualization of the research idea to the written presentation of the completed work. As my mentor and critic, she encouraged me to strive for excellence. My other committee members, Dr. Leonard Schatzman and Afaf Meleis provided valuable feedback. Barbara Bream, M.S.W., and Dr. Mary Thomas helped secure the research sites and made the collection of the data possible.

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Chapter I

Introduction

Purpose of the Study

The purpose of this comparative, exploratory study was to evaluate the relationship between the mental health professional's commitment to community mental health ideology and his role in the community service to the chronic mentally ill adult. The study compared the commitment to community mental health ideology of the mental health professionals working in two separate community settings: a specialized service center involved with only chronic, severely disabled mentally ill adults, and a community mental health center involved with various types of psychiatric patients.

Background

Until the late 1960's the care of chronic mentally ill adults were not a concern in community psychiatric treatment as these patients were most often maintained in large state facilities. State hospitals provided social support as well as fulfilled all the basic survival needs of chronic patients (food, shelter, and clothing). Community treatment programs and services for chronic psychiatric patients have been struggling to fulfill the same functions as the state mental hospitals of the past, often without realizing the full extent of these functions (Bachrach, 1979). To maintain in the community, the chronic patient needs not only psychiatric treatment, but assistance with living arrangements, finances, and social and vocational training. In fact, community psychiatric

treatment alone usually cannot maintain the patient. However, until recently, the special problems of chronic patients were not recognized by the mental health professionals at the community mental health centers who worked with various types of psychiatric patients. Often chronic patients were seen as unattractive clients by professionals in contrast to their other clients because chronic patients are difficult to work with, unmotivated, unable to take a responsible role in therapy, have a low potential for improvement, and high potential for rehospitalization (Bennett, 1977; Lamb & Edelson, 1976). Also, the organization of work at the community mental health center did not readily provide the time or institutional sanctions necessary to fulfill the unique needs of chronic psychiatric patients.

The community mental health movement of the 1960's was designed to provide for both psychiatric services to the general population and the deinstitutionalization of chronic psychiatric patients. This movement incorporated a community oriented public health service model and the principles of crises intervention, plus provided a framework for community treatment including deinstitutionalization. Deinstitutionalization was to remedy the social disability and institutional dependence of chronic patients caused by prolonged hospitalization by treating the institutionalized patients in their local communities. However, mental health professionals, including psychiatric nurses, encounter chronic mentally ill adults for whom community treatment appears inadequate and inappropriate. The literature supports the view that usual community treatment services for chronic patient population are uniform and inefficient (Bachrach, 1976; Herz, 1978; Bassuk & Gerson, 1978).

In the last few years, special units and programs have been established to provide community service solely to the chronic psychiatric patient population. Mental health professionals in these programs changed from a primary focus on psychiatric treatment (individual, group, and family therapy) to a focus on assisting chronic patients with the practical management of day-to-day living (medication maintenance, living arrangements, vocational rehabilitation, and financial assistance).

The investigator assumed that the emergence of a specialist role in the community service to chronic patients was relevant to improving the quality and outcome of this service. It was assumed that the specialist was better able than the generalist at the community mental health center to understand the nature of the problems and the unique service needs of the chronic population. Additionally, programs and services established specifically with the aim of serving the chronic psychiatric patient population should be providing mental health professionals with the time and institutional sanctions to focus on all aspects of chronic care and not just the traditional forms of treatment.

Conceptual Framework

The conceptual framework of the study is the Strauss, Schatzman, Bucker, Ehrlich, and Sabshin (1964) theory that institutional setting, treatment ideology, and profession are interdependent variables that affect psychiatric treatment. Ideologies are defined as belief systems or philosophies of treatment for the mentally ill. Ideologies specify the tasks necessary to accomplish the treatment and who is to perform these tasks. Ideology is important because in the absence of well-tested, empirically supported models, mental health professionals have tended to

function largely on the basis of their beliefs about the etiology of mental illness and its treatment. In essence, ideology largely defines treatment.

Strauss et al. (1964) maintained that ideologies are associated with institutional settings. Ideologies vary among different psychiatric institutional settings and become characteristic of them. The settings themselves are both selective and productive of different ideologies because of their working conditions. Institutional necessities impose limitations on the use of resources and the organization of treatment which affects the working conditions. The organization of work and interpersonal relations tend, therefore, to take different forms from one institution to another institution or even within parts of the same institution.

Belief systems have associated personality correlates such as conservatism and dogmatism. Mental health professionals are most receptive to those ideologies that best fulfill intrapsychic and interpersonal needs that address the desirable roles in professional social systems. Professional discipline affiliation strongly influences the professional's ideological position. Initially this occurs because ideological commitments are built into professional training and then later, circumstances under which professionals work tend to support certain ideological positions over others. The institutional locales usually encourage further development of whatever positions were originally held. Ideologies are also considered an important factor in the development and maintenance of an individual's role conception within his professional work setting.

Out of the study of ideology grew the identification of community mental health ideology. Community mental health ideology, which derives from the beliefs of the community mental health movement, has been most closely linked with the community treatment of chronic mental patients. The beliefs of community mental health incorporated a public health model that was community oriented with an emphasis on local services, community consumer participation, and primary and secondary prevention with the principles of comprehensive multifaceted services, continuity of care between these services, and consultation to community care-givers (Freedman, Kaplan, & Sadock, 1976). Although community mental health ideology has been linked with the community treatment/service of chronic psychiatric patients, there has been a dearth of research studies that have directly explored the relationship between this ideology and the community treatment of this population.

It has been assumed that commitment to community mental health ideology by mental health professionals translated into working well with chronic psychiatric patients in the community, fulfilling both their treatment and social service needs. However, the community mental health movement and the push for deinstitutionalization of the chronic mentally ill that accompanied it have been in existence since the early 1960's and the community treatment of chronics is still considered inadequate and inefficient. Hence, this assumption must be challenged. Stern and Minkoff (1979) maintain that community mental health ideology contains certain paradoxes that cause community treatment of chronic psychiatric patients to be problematic and unfulfilling for mental health professionals adhering to that ideology. Specifically, the community mental health ideology focus on educative primary and secondary prevention, the short-term crises intervention model, and the community

consultation/indirect service model do not really meet the needs of chronic patients in the community. Research findings of community treatment, summarized by Test and Stein (1978), have shown that chronic patients need tertiary prevention and long-term, direct service and treatment to function successfully in the community.

Research Question

Specific question for investigation. What is the relationship between commitment to community mental health ideology role and to community treatment of chronic psychiatric patients for mental health professionals in specialist roles and mental health professionals in generalist roles?

Hypotheses of the Study

1) There will be a significant difference in the Baker-Schulberg Community Mental Health Ideology Scale scores between the specialist and the generalist subjects.
2) The specialist subjects will score significantly higher on the Community Treatment of Chronic Psychiatric Patients Scale than the generalist subjects.

Operational Definitions

Commitment to community mental health ideology - to be determined by the subject's score on the Baker-Schulberg Community Mental Health Ideology Scale. A significantly higher score on this scale will indicate a strong commitment to community mental health ideology.

Community treatment of chronic psychiatric patients - to be determined by the subject's score on the Community Treatment of Chronic Psychiatric Patients Scale, a quanitative instrument developed by the investigator. Part I of the scale assesses staff perceptions of treatment practices/attitudes at their facility. Part II of the scale assesses the subject's knowledge of research findings in community treatment of chronic psychiatric patients. A significantly higher score on Part I indicates that the subjects perceive their treatment practices/attitudes as consistent with those best suited to meet the needs of chronic patients in the community according to empirical studies in the field. A significantly higher score on Part II indicates that the subject is knowledgeable about research findings in community treatment/service to chronic psychiatric patients.

Specialist role - those mental health professionals working in the specialized services center. They provide service exclusively to a special population of psychiatric patients, the chronic severely disabled mentally ill. Additionally, any mental health professional who spends 75-100% of his time delivering service/treatment to chronic patients will be considered to function in a specialist role regardless of his work setting (to be determined in the identifying data section of the Community Treatment of Chronic Psychiatric Patients Scale).

Generalist role - those mental health professionals working at the community mental health center. They provide service/treatment to various types of psychiatric patients, ranging

from psychologically healthy adults undergoing "transient situational disturbances" to the chronic severely disabled mentally ill. Additionally, any mental health professional who spends less than 75% of his service/treatment time with chronic psychiatric patients will be considered to function in a generalist role regardless of work setting.

Chronic psychiatric patients - those adult individuals diagnosed as schizophrenic (Diagnostic and Statistical Manual of Mental Disorders III) with a functional mental illness over one year's period of time and having had more than one hospitalization for this illness.

Chapter Two

Review of the Literature

Defining the Chronic Psychiatric Population

The President's Commission on Mental Health (1978) estimates that ten percent of the United States' population needs some form of mental health services. During 1975, 6.7 million people (three percent of the population) were seen in mental health services and 1.5 million were hospitalized. An estimated two million people have been diagnosed as schizophrenic, with approximately 600,000 of them receiving active treatment in any one year. Current estimates are about one percent of the population suffers from profound depressive disorders, and more than one million Americans have an organic psychosis of toxic or neurologic origin or permanently disabling mental conditions of varying causes.

Addressing the question of what is a chronic condition, the dictionary defines chronic as something that is prolonged, lingering, and/or recurrent. Applying this to a chronic mental illness, Craig and Hyatt (1978) state the following points:

> 1. Regression or lack of change in the patient's level of functioning (persistance or reappearance of symptoms) leads to recurring and/or long periods of treatment received from one or more types of mental health care services.
> 2. Helplessness and hopelessness are experienced by mental health staff, the family, and the patient.
> 3. Helplessness and hopelessness lead to rejection and isolation of the patient and patient resistance to change.
> 4. The patient's behavior is primarily dependent in nature, with a diminished level of functioning in interpersonal relationships, vocational and intellectual skills. (p. 140)

The estimates of the chronic population with functional psychoses is two and one-half to three million people, with 25-30% of them continuously living out in the community, 20-40% being institutionalized periodically, and the remainder continuously institutionalized.

Although the etiology and diagnosis of mental illnesses is controversial, there is agreement that these conditions often result in an impairment of the individual's overall functioning. With severe illnesses, incapacitating cognitive and behavioral symptoms are present that necessitate intervention and assistance from mental health professionals. When these symptoms become chronic, secondary effects occur that further interfere with the person's adjustment.

Institutional Care of the Chronic Mentally Ill

Chronic mentally ill adults are usually diagnosed as having a functional mental illness (schizophrenia or manic-depressive illness) and their regression in their level of functioning leads to recurring and/or long periods of treatment. These patients are characterized by Test & Stein (1978) as displaying high vulnerability to stress, deficiencies in basic coping skills, extreme dependency, difficulty with working in a competitive job market, and difficulty with interpersonal relationships. Because of these deficits, the past treatment of the chronic mentally ill was hospitalization, usually at large state facilities. This hospitalization with its prolonged custodial care caused even further disability. This type of care tended to lack stimulation, to exploit, and to infantilize the patient to such a degree that even when their illnesses were in remission they were unable to function outside the hospital. The care in the hospital itself had created social disability and institutional dependence.

The introduction of phenothiazine medications as treatment in the 1950's caused remissions in mental illnesses of many chronic patients and contributed to the belief that they could be deinstitutionalized and receive their treatment as out-patients in their local communities. The most effective treatment for the severe functional psychoses to date is psychotropic medications (Huey, 1977; Hogarty, Goldberg, & Schooler, 1975). But medications alone can prevent relapse, defined as rehospitalization, in only one-half of the cases over a period of two years. Medication treatment does not seem to be enough and supportive programs are needed to make the most of medication related remission or suppression of symptoms. Medication treated patients are often handicapped with residual psychoses and their pre-illness levels of adjustment that were often inadequate.

Transfering the chronic patients from the large state mental hospitals (in the 1960's as part of the community mental health movement) back to their local communities has proved to be problematic in spite of good intentions. The transfer failed to eradicate the patients' psychosocial disabilities or to eliminate the recurrence of acute episodes of their illnesses. Bachrach (1976) comments on these failures from a sociological point of view, concluding that deinstitutionalization is more than a process concerned with the locational aspects of patient care. It has philosophical, social, and political implications. This author espouses a functionalist framework that views many of the problems connected with the deinstitutionalization movement as closely related to a general failure to 1) understand the unique position of the mental hospital to American culture, and, 2) to make sufficient allowances for this uniqueness in the process of planning for the social change involved in the movement.

The mental hospital of the past provided more than just treatment to the chronic mentally ill. Besides providing assistance with the basic survival needs of food, clothing, and shelter, hospitalization addressed many of the psycho-social needs of the patients, such as contact with other people and a social support system. There is a difference between treatment of the chronic mentally ill population and service to this populaton. Service is a more inclusive term; it incorporates treatment defined as definite medical/surgical therapies with social services. Service to the chronic mentally ill does not address the prevention of the illness, but rather the control of the primary cognitive and behavioral symptoms and the secondary effects of inadequate social functioning caused by these symptoms.

Community Service to the Chronic Mentally Ill

Community service programs for the chronic mentally ill are currently struggling to identify and meet some of the same needs that the state mental hospitals addressed. Test and Stein (1978) summarized the research findings of community service to chronic psychiatric patients and concluded that this service is in its infancy and needs further research to define the variables and outcomes of successful treatments. The evidence so far suggests that chronic mental illness may be a lifelong disability that requires lifelong supports and direct, on-going interventions if the patient's improvement is to be maintained.

The feasibility of community treatment for the chronic population was initially considered because of the community mental health movement. The beliefs of the community mental health movement arose from a sociological view of mental illness, fostered by the receptive political

climate of the early 1960's. The movement's philosophical roots were in the civil libertarian emphasis on the rights of individuals and on the view that modification of the environment was the primary avenue to social change (Bachrach, 1978). The sociological view of mental illness as situational/environmental was in contrast to the existing individualistic/intrapsychic view of mental illness in which the individual is identified as an object of concern because of his deviation from some norm of health. There was a shift from a focus on the individual to a focus on large populations and their environmental situations (Ryan, 1972). The community mental health movement had developed in part as a reaction to the criticism of the medical model orientation to individual psychotherapy. The movement's beliefs and treatment methods focused instead on the importance of the analysis of the environment (Levy, 1976).

The passage by Congress of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 and this ideological shift resulted in the advent of the community mental health movement and the beginning of deinstitutionalization. The federal legislation and related guidelines from the Department of Health, Education, and Welfare called for the establishment of community based mental health centers and promised funding for such centers if they provided five essential services: in-patient care, out-patient care, emergency treatment, partial hospitalization, and consultation and education (Bassuk and Gerson, 1978).

The concept of community mental health addressed two objectives--the treatment and rehabilitation of the severely mentally ill within the community and promotion of mental health in general. The severely

mentally ill were to be served through the development of an extensive support system based on the community mental health centers and offering comprehensive and coordinated treatment and rehabilitation services. The second objective, the broad improvement of the nation's mental health, was to be accomplished largely by prevention programs originating in the mental health centers.

The beliefs of the community mental health concept encompassed a public health treatment/service model that was community oriented with an emphasis on local services and consumer participation. Programs were to be developed and evaluated according to the needs of the community. Continuity of care in the form of linkages between various services of the mental health center and liaison between agencies was stressed to insure minimal fragmentation and maximum optimal care. Consultation was to be provided to help the other care-givers in the community utilize mental health principles in their work, to enable them to handle the emotional problems of their clients with greater effectiveness. Community care-givers were to be taught to recognize the symptoms of mental illness to assist them with making appropriate referrals when necessary. The principles of preventitive psychiatry were stressed. Primary prevention, intended to eliminate the factors that cause or contribute to the development of mental illness, was to be accomplished through the consultation and education services provided by the mental health center staff to the other community care-givers. Secondary prevention, the early detection of disease and initiation of treatment, was to be provided by the mental health centers through their readily accessible care for acute illness in the form of emergency or crises services. Tertiary prevention, the elimination or reduction of

the residual disability after the treatment of the acute illness, was also to be addressed by the services of the mental health center (Freedman, et al., 1976).

Although the ideals of the community mental health movement were admirable, in reality it appears that its advocates probably made too many untested assumptions, especially in the area of deinstitutionalization. Bassuk and Gerson (1978) in a comprehensive review of the current status of deinstitutionalization conclude that implicit in the aims of the community mental health movement was the expectation that mental illness could be prevented and that even chronic patterns of severely disturbed behavior could be altered. The shortcomings of the initial legislation, the lack of an adequate system of follow-up care, insufficient funding, the probable impact of patients on communities, and the uncertainties of the components of effective psychiatric care were all ignored in the rush to implement community mental health and deinstitutionalization.

Bachrach (1978) goes further than the previous authors and describes three unvalidated assumptions of the philosophy of deinstitutionalization. First of all is that community mental health is a worthwhile enterprise and that community-based care is preferable to institutional care for most/all mental patients. The second assumption is that communities can and are willing to assume responsibility in the care of the mentally ill. Lastly, functions performed by the mental hospital can be performed equally well or better by community-based facilities.

Community care in England is reviewed by Hawks (1975) and he also addressed the assumptions in their comparable deinstitutionalization movement that may not in reality exist. The assumptions are the following:

1) The community with geographic and sociological characteristics cares and is therapeutic;
2) The community outside the hospital can become an extension of a therapeutic regime and favorable attitudes exist toward this extension,
3) The number of patients requiring long-term care will decline, which will validate a belief in the efficacy of psychiatric treatment,
4) Patients previously kept in the hospital for long periods of time could be discharged now after short periods of hospital treatment without adverse consequences,
5) New rehabilitation programs in the communities are successful with all patients, and
6) The public health treatment/service model is more appropriate to the care of the mentally ill than the old medical model.

As a final point, Hawks reports that the concept of prevention, emphasized in the public health model, is very seductive to those confronted with the continued presence of the mentally ill in society and the failure of psychiatry to eliminate this burden on society. Prevention does not really provide a new hope; it continues to be difficult to achieve due to the still limited knowledge of the causes and/or early stages of mental illness.

Community Mental Health Treatment Ideology

Several studies, summarized by Schulberg and Baker (1975), have shown that psychiatric treatment in the hospital and the community is influenced by the treatment ideologies of mental health professionals and

the institutional settings in which these professionals work. Three main ideologies in psychiatry currently in use (somatotherapeutic, psychotherapeutic, and sociotherapeutic) were identified from empirical studies beginning in the 1950's. Gilbert and Levinson (1957) studied the distribution of ideologies among mental hospital units using the Custodial Mental Illness Scale which they developed to measure custodialism and humanism as ideological orientations. They found that hospital units with the most custodial management policy were staffed by individuals with the most custodial ideologies and the most authoritarian personalities. In a related study of humanistic orientation, Sharaf and Levinson (1957) examined the distribution of psychotherapeutic versus sociotherapeutic ideology among psychiatric physicians at the Boston Psychopathic Mental Hospital. Psychotherapeutic ideology had its origin in Freudian psychoanalytic theory and sociotherapeutic ideology was developed by Jones (1953) in his therapeutic hospital milieu model. Sharaf and Levinson viewed the psychotherapeutic and sociotherapeutic ideology patterns as opposite poles of the same continuum. A third study, Hollingshead and Redlich (1958) distinguished two other major types of therapeutic ideologies in psychiatry, the directive-organic versus the analytic-psychotherapeutic. The directive-organic (somatotherapeutic) ideology viewed mental illness as having an organic cause therefore requiring somatic treatments.

In a classic sociological study of public and private psychiatric hospitals in Chicago, Strauss et al (1964) integrated into a single measurement scale the somatic dimension refined by Hollingshead and Redlich with the psychotherapeutic and sociotherapeutic dimensions

identified by Sharaf and Levinson. The investigators initially hypothesized that all three orientations represented separate and distinct ideologies. Their data, however, showed that only the sociotherapeutic orientation was independent since the somatotherapeutic and psychotherapeutic orientations were strongly negatively correlated, suggesting the existence of a continuum of psycho- versus somato- ideology. Armor and Klerman (1968) found factor analytic support for the ideologies of somatotherapy and psychotherapy using data from a nationwide survey of hospital psychiatrists. But Armor and Klerman also predicted that sociotherapy was developing into its own full idological status.

Baker and Schulberg (1967) agreed that sociotherapy was a separate ideology. They combined the sociotherapeutic dimension and the beliefs of the community mental health movement to develop the Community Mental Health Ideology Scale. The final version of the scale was developed on the responses from various criterion groups of mental health specialists comprising a total of 484 individuals. The first category of respondents was composed of four criterion groups whose members were thought to be highly oriented to community mental health:

1) Graduates of the Harvard School of Public Health and Harvard Medical School Community Mental Health Training Program,
2) Graduates of the Columbia University School of Public Health and Administrative Medicine,
3) Members of the Harvard Laboratory of Community Psychiatry Visiting Faculty Seminar,
4) Participants in the 1965 Swampscott Conference on Training in Community Psychology.

The second category of respondents consisted of random samples from three national professional associations:

5) The American Psychological Association (Division of Psychology),

6) The American Psychiatric Association,

7) The American Occupational Therapy Association (Psychiatric Occupational Therapists).

The third category of respondents consisted of random samples of members from two other professional groups which, it was assumed, would contain psychiatrists more negatively oriented to community mental heath ideology:

8) The American Psychoanalytic Association,

9) The Society for Biological Psychiatry.

Results of mail questionnaires confirmed the predictions of the study. The four criterion groups expected to score highest on the Community Mental Health Ideology Scale did so; the Harvard graduates achieved the highest mean score of all the nine groups. Of the two criterion groups expected to score lowest, the American Psychoanalytic group achieved the lowest mean score and the Society for Biological Psychaitry the third lowest score (The American Psychiatric Association was second lowest).

Langston (1970), in a replication of the Baker and Schulberg initial research of the development of the scale, studied the adherence of the staffs of two Houston, Texas community mental health centers to community mental health ideology as measured by the CMHI Scale. The results obtained by the research corresponded to those in the earlier study. As with the Baker and Schulberg study (1967) Langston found

that groups of psychologists, occupational therapists, and psychiatrists were arranged in descending order in terms of degree of their agreement with community mental health ideology. In addition, Langston investigated psychiatric nurses and social workers. He found that the mean CMHI Scale score for nurses was lower than his group of occupational therapists, but higher than his group of psychiatrists. The social workers in the study received a group average on the CMHI Scale higher than all the other groups studied.

Since the initial development of the Community Mental Health Ideology Scale, this instrument has been widely distributed as a published test, has been employed by various program evaluators in a number of mental health settings around the country, and used in research studies. The findings of the research studies show that the Ideology Scale successfully differentiates mental health professionals working in traditional settings from those working in innovative mental health settings (Bresskin, Wolff, & Witzke, 1972). Individuals with strong adherence to community mental health ideology tended to emphasize community oriented roles, work in community settings, and be younger than individuals with low adherence (Howard & Baker, 1971; Baker & Schulberg, 1967). Also, strong adherence to community mental health ideology correlated negatively with the personal characteristics of the need for order and deference and with dogmatism and political-economic conservatism (Penn, Baker, & Schulberg, 1973; Baker & Schulberg, 1969).

Professional Roles in Community Service

As discussed previously in the conceptual framework of the study, role is an important variable in professional social systems and has a relationship to treatment ideologies. Role is defined from a symbolic interactionist view as a cluster of related meanings, communication symbols, and values that guide and direct the individual's behavior in a given social setting (Blumer, 1969). Professional roles, like all social roles, are formed from social interactions with others through a negotiative process, the meaning of the role being taken from the meaning of other counterroles.

The community mental health movement spawned a multifaceted generalist role for the mental health professional. The community mental health center was designed to provide a range of services in order to meet the mental health needs of the community's total population. The mental health professional was expected to deliver service to various types of psychiatric patients and to function in a variety of sub-roles such as therapist, consultant, and educator. The generalist role most likely was effective in meeting the needs of the general population, but the chronic psychiatric patient in the community provided a new challenge.

Williams and White (1978) discuss the roles available in mental health settings and conclude that the specialist role is one that can bring about change and overcome resistance to change. This occurs because our educational system, in general, is based on the preparation of individuals for specialization and, subsequently, specialists are more accepted by service institutions than other change agent roles. The specialist role holds a relatively established position within the system

and the individual occupying it may use his membership status as legitimization for bringing about change. The change process itself is dependent on the specialized knowledge of the individual in the specialist role, the individual's ability to convey his knowledge, and on his status as a member of the social system.

The existence of specialist role in the community service to the chronic mentally ill adult may effect some change in the delivery of psychiatric care to this population. Because of the unique properties of the role, the individual occupying it may act as a catalyst to establish broadened treatment/service approaches that meet the needs of the chronic population.

Chapter Three

Methodology

General Study Design

This comparative, exploratory study was designed to evaluate the relationship between the mental health professional's commitment to community mental health ideology and his role in the community treatment of chronic psychiatric patients over a one-month period of time. Data was collected by administering the Schulberg and Baker Community Mental Health Ideology Scale and a measurement of community treatment of chronic psychiatric patients, scale format, developed by the investigator, to two groups of subjects (total N=34). One group of subjects, consisting of mental health professionals working in specialist setting (N=16), and another group of subjects consisting of mental health professionals working in a generalist setting (N=18), were used.

Research Settings

The subjects were selected from mental health professionals working in two community treatment/service facilities that were part of a county mental health services in the San Francisco Bay Area. The county mental health services delivery system (public sector) consisted of varous out-patient and in-patient facilities for the treatment of children and adults (psychiatric patients).

Generalist setting. One of the community settings of the study was a community mental health clinic. This clinic provided, through direct services; out-patient individual and group therapies, family therapy, assessment, supportive services, and referrals for various

types of psychiatric patients, including chronic patients, in its catchment area. This setting was chosen initially because it was the only out-patient psychiatric clinic in the county mental health care services system, public sector, that still had all the components of the traditional community mental health centers. The community mental health clinic was partially funded by an NIMH grant and provided, either directly or through contractural arrangements with other services, out-patient psychiatric care, in-patient psychiatric care, emergency/ crises care, and consultation and education. The investigator assumed that all the mental health professionals working at this clinic would be functioning in a generalist role, spending less than seventy-five percent of their service time with chronic adult psychiatric patients. This turned out to be a false assumption because of the characteristics of the center service area. There were approximately seventy-nine board and care homes with 475 beds in the center's service area. The service area also includes a disproportionate number of persons who were poor, members of racial minorities, unemployed, financially dependent, and in crowded housing. The private sector has not been attracted to the area, so residents relied heavily on public mental health programs for their psychiatric care and treatment.

The community mental health center had an annual caseload of approximately 1550 clients. The majority of these clients (93%) had a gross monthly income of less than $500.00 and belong to ethnic/racial minority groups (Black 54.2%, Spanish Surname 12.5%). The major preliminary diagnoses of these clients were the following: schizophrenia 36%, transient situational disturbances 31%, neurosis 17%, and personality disorders 10%.* Staff at the center consist of twenty-seven clinical

staff, two of whom are involved only in administration, and nine clerical staff. The clinical staff providing direct patient services consisted of fifteen members of three different professional disciplines; four psychiatrists, nine psychiatric social workers, and two clinical psychologists, and nine members of a new category of mental health specialists which includes psychiatric technicians and aides, plus one recreational therapist.* Direct patient services in general appear to be provided to the clients at the time of their visits to the mental health center; some out-reach and services in the community are provided through a community center which mainly served the adult chronic population.

The community mental health center was housed in a professional building in a shopping center. The facility included interveiwing offices, group therapy rooms, a craft room, a kitchen, administrative offices, and a clerical area.

Specialist setting. The other community setting of the study was a specialized services center, housed at a separate location. This center provides services exclusively to chronic, severely disabled adult psychiatric patients for all of the county. The services consist of case-management, treatment-planning, placement services (locating appropriate facilities or residences in the community) consultation, monitoring of patients in long-term community locked facilities and the State Hospital, and linking patients to aftercare (post-hospitalization) services.

*Demographic information on clients and staff obtained from 1978 Program Statement.

The special center was initiated in 1976 with only a placement services component; in 1979 the case management functions were added. The case management monthly caseload consisted of one hundred clients with the following primary diagnoses: schizophrenia 91%, major affective disorder 5%, and other 4% (organic brain syndrome, personality disorder). The majority of the clients (95%) were supported on SSI or SSD, federal disability programs. Forty-five percent of the clients had a voluntary legal status and 55% were on a conservatorship. The racial breakdown was 52% caucasian, 39% black, and 8% Spanish surname.** The placement services component, including the liaison and consultation services, provides service to approximately 25-30 clients per month.

The center staff consist of eighteen persons that were county employees: one center director (psychiatric social worker), twelve clinical staff, four clerical staff, and one transportation worker. The clinical staff includes a one-half time psychiatrist, two clinical nurse specialists, four psychiatric social workers, two rehabilitation counselors, and three mental health specialists. Working in close affiliation with the county staff were seven psychiatric social workers from the State of California, who were assigned to the county caseload.**

The specialized services center is located in a county office building. The clients do not come into the center to receive services in contrast to the majority of clients at the East community mental health

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**Information on clients and staff obtained from June 30, 1980 Program Statements

center. The staff go out into the community to contact them. The physical space at the specialized services center consisted of a clerical pool area, individual work cubicles, a few large shared offices, and a large meeting room.

Comparing the Two Research Settings

Of the differences between the two research settings described regarding services offered, client characteristics, staffing, and location, a few need to be highlighted. Client diagnoses of schizophrenia which is generally associated with chronic patients, are more prevalent at the special center than at the community mental health center (95% versus 36% respectively). Also, the clients of the special center have some special characteristics: 55% are on conservatorship and 95% are supported by disability. Additionally, the client referral process is different in each center. The majority of the case management clients at the Special center are referred from the State Hospital (69%). The other clients come from private sources (14%) and other county facilities (17%) the county General Hospital, locked facilities, board and care homes, and half-way houses).** The community mental health center clients, on the other hand, are referred from local psychiatric hospitals, the county placement unit, the county hospital, and walk-in/ drop-in center services.

The differences between the two research settings point toward the probability that, even though they both provide services to chronic

**Information on clients and staff obtained from June 30, 1980 Program Statements

adult psychiatric patients, there is a difference in the type of chronic patient served by each center. The chronic patients are different in terms of the severity of their social dysfunction and the social support system available to them. The special center was established specifically to serve those chronic patients more severely disabled, those patients who generally do not connect with out-patient follow-up post-in-patient hospitalization (locally or at the State hospital) and fall "between the cracks" (Segal, Baumohl, & Johnson, 1977): in contrast, the community mental health center catchment area chronic patients generally have to be able to follow through with making and keeping their appointments at the center.

The investigator attended a general staff meeting at each setting in June of 1980 and obtained the staff's verbal consent to proceed with the study. The acutal data-gathering did not begin until August of 1980 because of some delays encountered with obtaining written permission from the County Research Committee (see Appendix B). This time delay resulted in a new variable that may affect the findings of the study. As of July 1, 1980, the community mental health center obtained a new center director and organizational/ program changes were initiated. The major thrust of the anticipated changes at the center appeared to revolve around moving away from a traditional community mental health center concept (NIMH funding grant was to be discontinued) to a program cost-effective for the county with certain established priorities (transferring more mental health care into the private sector, contracting for services with other agencies, and decreasing State Hospital bed utilization).

Research Subjects

The research subjects (total N=34) were selected from the mental health professionals working in the two reasearch settings (special center N=16, CMH N=18). The subjects consisted of mental health professionals from the following groups: psychiatrists, psychologists, psychiatric social workers, psychiatric clinical nurse specialists, and mental health professionals. The subjects were involved in providing service and treatment to the adult psychiatric patients at the two research settings directly to the patients themselves and indirectly to the care-takers of the patients. Clerical and administrative staff were excluded.

Instruments

Community Mental Health Ideology Scale. The Community Mental Health Ideology Scale (CMHI) was developed by Schulberg and Baker (1967) in a Likert-type attitude scale format. According to its developers, the items of the scale are constructed on the basis of the following five conceptual categories:

1) A population focus - The view that the mental health professional should be responsible not only for the individual patients with whom he has contracted for treatment, but for the entire population of both identified and unidentified potentially sick members of the community;
2) Primary prevention - The concept of lowering the rate of new cases of mental disorder in a population by counteracting harmful forces before they have had a chance to produce illness;

3) Social treatment goals - The belief that the primary goal of treatment is not to reconstruct the mental patient's personality, but rather to help him achieve social adjustment in an ordinary life situation as soon as possible;

4) Comprehensive continuity of care - The view that there should be a continuity of professional responsibility as the patient moves from one program to another in an integrated network of care-giving services; and,

5) Total community involvement - The belief that the mental health professional is only one member of a group of community agents caring for the mentally ill and that he can extend his effectiveness by work with and through other people.

The Community Mental Health Ideology Scale consists of thirty-eight items with provision made for respondents to circle one of six categories for each item (strongly, moderately, or slightly agree; and strongly, moderately, or slightly disagree). Half the items are worded positively and half are worded negatively. On positively worded items, strong agreement is scored seven and strong disagreement is scored one with intermediate scores given to the other levels of agreement or disagreement. For negatively worded items, the opposite of this scoring system exists. When no clear response is given, a score of four is assigned to that item. A high total score on the CMHI Scale indicates that the respondent strongly adheres to (is committed to) community mental health ideology and, conversely, a low total score indicates that the respondent adheres weakly or not at all to community mental health ideology.

The initial evidence indicated that reliability for the CMHI Scale was acceptable. The Cronbach Alpha (generalized Kuder-Richardson formul 20) for the group of respondents on which the scale was originally developed is .94, and split-half reliability of .92 was obtained (Baker & Schulberg, 1967). Initial evidence for the validity of the CMHI Scale included research findings indicating that the scale successfully discriminated groups known to have positive community mental health views from random samples of mental health professionals. CMHI Scale scores were also shown to relate significantly to self-reported questionnaire responses on degree of identification with a community mental health organization, interest in keeping up with new developments in community mental health, and preference for a symposium on recent advances in community mental health (Baker & Schulberg, 1967). Scores on the CMHI Scale were also shown to relate significantly to the connotative meanings assigned community mental health on a nineteen-item semantic differential rating form (Schulberg & Baker, 1967). Subsequent research has provided additional evidence of the reliability and validity of the CMHI Scale (Langston, 1970; Breeskin, Wolff, & Witzke, 1972; Howard & Baker, 1971; Gross, 1972).

This research study differed from past studies utilizing the Community Mental Health Ideology Scale in that two groups of subjects were compared that could be expected to score high on the Community Mental Health Ideology Scale because they both work in innovative community settings. The difference between the groups involved the quantity and quality of their involvement with chronic, severely disabled psychiatric patients. Also, past studies utilizing the Community Mental Health Ideology Scale have compared various professional disciplines in mental

health regarding their adherence to community mental health ideology. This study does not compare professional disciplines, but does compare differences in roles, specialist versus generalist.

Community Treatment of Chronic Psychiatric Patients Scale. The Community Treatment of Chronic Psychiatric Patients Scale (CTCP), composed of two parts, was developed by the investigator from a review of current literature on the status of the deinstitutionalization movement and the community treatment needs of the chronic psychiatric population (Bachrach, 1979; Minkoff, 1979; Talbott, 1979). Part I consists of eighteen items that relate to staff perceptions of which attitudes/values and treatment practices exist at their facility. These items were mainly derived from the Cotton et al. (1979) and Stern and Minkoff (1979) studies that point up that mental health professionals working with the chronic psychiatric population in the community should have:

1) a broadened treatment strategy that entails the social and economic needs of the chronic population as well as therapy and medication regimes,
2) an awareness of the resources and vehicles for continuity of care between community treatment/services (in-patient and out-patient),
3) a tolerance for chronicity and the capacity to measure subtle changes in chronic patients,
4) clinical leadership with a commitment to the success of the deinstitutionalization movment (community treatment of chronic patients), and,
5) sources of enhancement of self-esteem and recognition of professional ability in work with the chronic population.

Part II consists of twenty-two items taken from Test and Stein's (1978) summary of research findings of community treatment of chronic psychiatric patients. Items in Part II are composed of the following categories:

1) Hospital treatment - is ineffective in establishing sustained community adjustment post-discharge, no matter the length of hospitalization;
2) Alternatives to hospitalization - exist for the treatment of acute episodes and are effective; and,
3) Aftercare studies - aftercare reduces recidivism and is more effective in keeping patients on medications, specifics:
    a) drug treatment - psychotropic medications reduce hospital readmissions, but sociotherapy and medications together have the best effect,
    b) groups versus individual therapy - in outpatient treatment, there is a high drop-out rate for both types of therapy and neither one may be the treatment of choice for chronic patients,
    c) milieu approaches - high input milieu treatment (day care, half-way houses, etc.) rather than out-patient clinic treatment and board and care homes, is more effective treatment (does not always reduce hospital readmissions, but increases psycho-social functioning).

The Community Treatment of Chronic Psychiatric Patients Scale makes a provision for the respondent to circle one of four categories regarding each of the total forty items. In Part I the respondents can circle if the item is strongly, moderately, slightly, or not at all de-

scriptive of their actual treatment/service practices; and in Part II the respondents can circle if the item is strongly, moderately, slightly, or not at all a valid (truthful) statement. Half the items are worded positively, and half are worded negatively. On the positively worded items, strong responses are given a score of four and not at all responses are given a score of one, with the other responses receiving scores of two or three. On negatively worded items, the opposite system is used. There is a total score, Part I score, and Part II score for each respondent.

An initial scale, developed by the investigator, consisted of items only from Part II of the final scale, but when pretested on mental health professionals from various disciplines working in specialist and generalist roles with chronic patients, it did not discriminate adequately. Part I of the final scale was then added and again tested on the same mental health professionals, this time with better results. None of the pre-test subjects were used in the final study. The final version of the scale was judged to have face validity by a panel of experts in the treatment of chronic psychiatric patients.

Procedure Followed to Collect the Data

After receiving general information about the nature and purpose of the study, each subject in the study received instruction from the investigator, written and oral, as to how to complete the two scales of the study (Community Mental Health Ideology Scale and Community Treatment of Chronic Psychiatric Patients Scale). All the subjects received the same information and instructions from the investigator before completing the scales. The scales were passed out and collected

by the investigator and took approximately fifteen minutes each to complete. The scales were administered only once to each of the subjects. The subjects completed the scales in one of two separate group meetings (one meeting at each of the two research settings). Each meeting had the investigator in attendance.

Precautions to Minimize Risks

The rights and well-being of all the mental health professional subjects in this study were protected. Each subject received a clear explanation of the goals of the research and the identity of the nurse investigator conducting the study. The voluntary nature of participation was stressed; no subject was obliged in any way to answer questions or complete the scales utilized in the study. Nor was any subject's present or future employment status in any way affected by participation in the study. The employer of the subjects and/or their immediate supervisor did not have access to the individual subject's completed scales. The anonymity of the subjects was protected since names on the scales are not requested.

Also, the rights of the county mental health services agency were protected. Written permission was obtained in advance from the county's Mental Health Services Program Evaluation Unit--Research Committee to conduct the study. The investigator will comply with the Research Committee's request for submission of the final results of the research two weeks prior to any publication or dissemination.

The investigator contends that this study placed the subjects only at minimal risk regarding their psychological well-being, possibly generating some concerns regarding the treatment of their chronic psychiatric patients. To counteract this, the investigator stressed the exploratory

nature of the study and answered any questions the subjects had. No attempt to use data obtained during the study in any way injurious or unacceptable to the individual subjects or to the county mental health services agency occurred. The rights of all participants to feedback about findings will be respected.

Chapter Four

Data Analysis, Results, and Discussion

The research results are presented in three sections. The first section discusses the nature of the sample; the second, the data analysis; and last, the results of the data analysis are presented and discussed.

Nature of the Sample

Identifying and demographic data (facility, age, sex, professional discipline, job title, years working at job) plus information regarding working with chronic psychiatric patients (preferred patients, percentage of time involved with chronic patients, special training/education, satisfaction working with chronic patients) was obtained on all the subjects. The results of this data on the research subjects is presented in Table I (page 41) and in Table II (page 42).

In comparing the subjects at the two settings from the data in Table I and II, it is obvious that there are some similarities and differences. Age and sex distributions are similar. There are similarities regarding professional discipline: psychiatric social workers and mental health specialists are most numerous in both settings. The community mental health center has more psychiatrists, whereas the special center has psychiatric clinical nurse specialists.

Mean number of years working with chronic psychiatric patients turned out to be comparable for both settings and so did preference for

types of psychiatric patients. In both settings, specialist and generalist, the subjects preferred most to work with chronic schizophrenics and first break schizophrenics. It is noteworthy that the order is reversed: at the generalist setting the largest preference was for chronic schizophrenics, but at the specialist setting the largest preference was for first break schizophrenic patients.

In both settings, most of the subjects stated that they had had special training/education in the treatment of chronic mental illness. Most of this training/education turned out to be on the job training and education as part of initial professional education. Some subjects found working with chronic psychiatric patients frustrating, while others found it satisfying, regardless of setting. Again, the order of the majority responses was reversed: in the specialist setting most of the subjects found the work frustrating while at the generalist setting most of the subjects found the work satisfying.

Of most interest in the data on the subjects was the fact that the responses to the question of percentage of treatment/service time involved with chronic psychiatric patients were unexpected. The investigator had assumed that the generalist setting had mental health professionals functioning only in generalist roles, operationally defined as spending less than 75% of their treatment/service time with chronic psychiatric patients. As it turned out, only nine subjects (one-half of the total N of 18) functioned in generalist roles. In addition, the assumption that the specialist setting contained mental health professionals functioning only in specialist roles, operationally defined as spending more than 75% of their treatment/service time with chronic psychiatric patients was also false. Only ten subjects (62.5% of the

total N of 16) functioned in specialist roles. It is unknown what other roles the subjects had since the questionnaire did not request this information. This finding regarding the subjects resulted in a modification of the general study design. Rather than there being only two groups of subjects for comparison, four groups would be compared: specialist by setting versus specialist by role, and specialist by role versus generalist by role.

One of the most interesting findings of the study relates to the subject characteristics. More of the subjects at the specialist setting than at the generalist setting, regardless of role, found working with chronic psychiatric patients frustrating and stated first break schizophrenics as their preference in patient populations. The opposite finding that the mental health professionals at the community mental health center would show these attitudes and preferences was expected. To explain the finding, it is necessary to remember that the chronic patients at the specialist setting are more severely disabled than those at the community mental health center. The chronic patient characteristics and possible staff burn-out may have caused the unexpected results.

Lamb (1979) discusses the phenomenon of staff burn-out in work with longterm patients. He reports that this phenomenon occurs when mental health professionals do not recognize that chronic patients vary greatly in their potential for rehabilitation. The absence of this recognition can lead to staff having unrealistic expectations of the patients and accompanying frustration. Often contributing to the situation, is administrative pressure to produce impossible results. Since the patients at the specialist center were more severely disabled than at the

generalist center, it may be that the specialist patients required more attention with less results and led to more rapid staff burn-out.

Data Analysis

The difference between the two groups of subjects (specialist and generalist by role and setting) regarding community mental health ideology and community treatment of chronic psychiatric patients was evaluated by the use of T-test statistics. This wasdone by comparing the means of the total scores on the Community Mental Health Ideology Scale and the total and subscale scores on the Community Treatment of Chronic Psychiatric Patients Scale of the specialist by role and setting group of subjects with the means of the total score on the Community Mental Health Ideology Scale and the total and subscale scores on the Community Treatment of Chronic Psychiatric Patients Scale of the generalist by role and setting group of subjects.

The relationship between community mental health ideology and the community treatment of chronic psychiatric patients within the specialist group by role and setting of subjects and within the generalist by role and setting group of subjects was also evaluated through the use of Pearson-product correlation statistics. This was accomplished by determining the correlation of the individual total scores on the Community Mental Health Ideology Scale with the individual total and subscale scores on the Community Treatment of Chronic Psychiatric Patients Scale of the subjects within each group.

The relationship between community mental health ideology and the community treatment of chronic psychiatric patients for all the subjects, specialist and generalist by role and setting was evaluated through the use of Pearson-product correlation statistics. This was accomplished by

Table I
Data on Research Subjects - Comparison of Settings

Specialist Setting: Special Center N = 16		Generalist Setting: Community Mental Health Center N = 18
Age:		
Range 29-53 years. Mean 40.5 years. S.D. 7.58		Range 28-60 years. Mean 42.8 years. S.D. 10.58
Sex:		
Male - 9 subjects Female - 7 subjects		Male - 7 subjects Female - 10 subjects Unspecified - 1 subject

Professional Discipline:

Psychiatric Social Worker (3 with State of California)	9	Psychiatric Social Worker	6
Mental Health Specialist	3	Mental Health Specialist	5
Psychiatric Clinical Nurse Specialist	3	Psychiatrist	3
Rehabilitation Counselor	1	Psychologist	1
Psychiatrist	1	Recreation Therapist	1
		Refused to Specify	2

% of Time Involved with Chronic Psychiatric Patients;

	75-100% Time	
10 subjects (7 P.S.W., 1 Rehab Coun., 2 Clin. Nurse Spec.)		9 subjects (3 Psychiatrists, 3 M.H. Spec., 2 Unspec., 1 Recreation Therapist)
	50%-75% Time	
4 subjects (3 M.H. Spec., 1 P.S.W.)		7 subjects (2 M.H. Spec., 4 P.S.W., 1 Psychol.)
	25%-50% Time	
0 subjects		2 subjects (2 P.S.W.)
	0%-25% Time	
2 subjects (1 psychiatrist, 1 P.S.W. with State of California)		0 subjects

Table II
Data on Research Subjects - Comparison of Settings

Specialist Setting: Special Center N = 16		Generalist Setting: Community Mental Health Center N = 18	
Preference for Types of Psychiatric Patients:			
1st Break Schizophrenics	7 subjects	Chronic Schizophrenics	5 subjects
Chronic Schizophrenics	4 subjects	1st Break Schizophrenics	3 subjects
Personality Disorder	1 subject	Personality Disorder	2 subjects
Affective Disorder	1 subject	Affective Disorder	2 subjects
Refused to Specify	3 subjects	Refused to Specify	6 subjects
Years Working with Chronic Psychiatric Patients:			
Range 1.5-21 years. Mean 7.03 years. S.D. 5.18		Range 1-25 years. Mean 9.06 years. S.D. 7.79	
Special Training/Education in Treatment of Chronic Mental Illness			
Yes - 10 subjects. No - 6 subjects.		Yes - 16 subjects. No - 2 subjects.	
Feelings Regarding Work with Chronic Psychiatric Patients:			
Work is Satisfying	4 subjects	Work is Satisfying	9 subjects
Work is Furstrating	9 subjects	Work is Frustrating	7 subjects
Work is both Satisfying and Frustrating	3 subjects	Work is both Satisfying and Frustrating	2 subjects
Answers for Subjects Working Over 75% of Their Time with Chronic Patients			
Work is Satisfying	3 subjects	Work is Satisfying	6 subjects
Work is Frustrating	5 subjects	Work is Frustrating	2 subjects
Both	2 subjects	Both	1 subject

determining the correlation of the individual total scores on the Community Mental Health Ideology Scale with the individual total and subscale scores on the Community Treatment of Chronic Psychiatric Patients Scale for all the subjects.

Results and Discussion

Community Mental Health Ideology: Results for all subjects. The results of the total scores for all the subjects (N=34) on the Baker-Schulberg Community Mental Health Ideology Scale presented in Table III below show that the majority of the subjects (30) score above the midpoint of the possible range of the scores. The mean of the scores is 201 points, well above the midpoint of the range of the scores attainable on the scale (152 points). In contrast to past studies utilizing the Baker-Schulberg Scale, the distribution of scores according to professional disciplines shows no definite pattern. All the disciplines represented by the subjects are almost uniformly distributed throughout the range of total scores obtained.

Table III

Results of CMHI Scores for All Subjects (N=34)

Specialists and Generalists

Community Mental Health Ideology Scale:		
Range of Total Scores	132-244	(Possible Range 38-266)
Mean of Total Scores	201	(Midpoint of possible range = 152)
Standard Deviation	32.37	

After dividing the range of scores attained by the subjects into top and bottom halves (top half: 213-244, bottom half: 132-204), some differences in subject characteristics emerge. The top half contains more males than females (76% males and 24% females) and the bottom half reverses this position (71% female and 29% male). Of the subjects in the top half, 71% were in the specialist/role but only 47% in the specialist/setting. Only 29% of the top half group were in the generalist/role, but 53% were in the generalist setting.

Discussion of CMHI Results for all subjects. This finding indicates that the majority of the subjects moderately to strongly adhere to community mental health ideology. This result could have been predicted from past studies using the CMHI scale; the studies showed the subjects in community settings usually show strong adherence to the ideology. The differences in subject characteristics in the top and bottom halves may be irrelevant and only a result of the small sample size. This appears to be particularly true of the sex differences in the top and bottom half scores. Of interest is the finding that the specialist/role group of subjects had the highest percentage in the top half of CMHI scores. This finding, although difficult to generalize because of the small sample and limitations of the original study design, may be an indication the community mental health treatment ideology is strongly adhered to by those working exclusively with chronic patients.

CMHI Between group comparisons. Between subject group comparisons of total scores on the Baker-Schulberg Community Mental Health Ideology Scare are presented in Tables IV and V. According to the original group categories (specialist/setting versus generalist/

setting) and the added categories (specialist/role versus generalist/role), the two between group comparisons showed no significant results. The mean of the generalist/setting subjects' scores is slightly higher (0.94 points) than the mean of the specialist/setting subjects' scores, but this is not significant at $p < 0.05$ with T-Test statistics.

Table IV

CMHI Between Group Comparisons:
Specialist/Setting versus Generalist/Setting

	Specialist/Setting N=16			Generalist/Setting N=18				
	Range	$\bar{x}$	SD	Range	$\bar{x}$	SD	T-test	P
Community Mental Health Ideology Scale (CMHI):	132-242	200.5	36.14	149-244	201.44	12.10	F'=1.48 15 and 17 DF	0.43

Comparison of the specialist/role and the generalist/role subject groups shows that the mean of the specialist/role subjects' scores is higher than the mean of the generalist/role subjects' scores by 23.43 points. This difference is not significant at $p < 0.05$ with T-test statistics.

Table V

CMHI Between Group Comparisons:
Specialist/Role versus Generalist/Role

	Specialist/Role N=19			Generalist/Role N=15				
	Range	$\bar{x}$	SD	Range	$\bar{x}$	SD	T-test	P
Community Mental Health Ideology Scale (CMHI):	149-242	211.36	27.46	132-244	187.93	34.26	F'=1.56 14 and 18 DF	0.37

Discussion of CMHI between group comparisons. The findings of the study do not support the hypotheses of the study. Hypothesis Number One that stated there would be a significant difference in the Baker-Schulberg Community Mental Health Ideology Scale scores between the specialist and the generalist subjects was not validated. The difference between the means of the specialist/setting and the generalist/setting subject groups was small and not significant. Although regrouping the subjects into specialist/role and generalist/role categories produced larger differences between the means of the two groups, the difference was still not significant. The specialist/role group had a higher mean than the generalist/role group, and almost all subjects scored above the midpoint of the possible range.

This finding could be interpreted to mean that community mental health ideology may, after all, be a useful ideology for mental health professionals working with the chronic psychiatric patient population. The ideology may, in fact, be the preferable one if the higher mean for the specialist/role group over the generalist/role group, although not significant, is an indication of a strong trend. In general, regardless of setting or role, the majority of subjects adhered strongly to community mental health ideology.

Community Treatment of Psychiatric Patients Scale: Results for all subjects. The subject scores on the CTCP are broken down into total, Part I and Part II scores because there is a question about whether or not Part I and Part II measure two different aspects of the same unity (community treatment of chronic psychiatric patients). Part I assesses the subject's perception of the treatment practices and values at his work setting while Part II assesses the subject's knowledge of the

current research findings of community treatment of chronic psychiatric patients. An analysis of the properties of the scale done using the scores of the current sample shows a split-half reliability correlation coefficient for the total scale of 0.5938. The correlation between Part I and Part II equals +0.41347 and is significant at $p<0.05$. These findings confirm that the internal consistency of the CTCP scale is too low and that the parts of the scale measure somewhat diverse entities. It is probable that knowledge of research findings does not really impact on actual treatment practices/values in community treatment of chronic patients. A different outcome measure or assessment is required to obtain a more accurate view.

The results of the total, Part I, and Part II scores on the CTCP for all the subjects (N=34) is presented in Table VI. The range of the total scores achieved by the subjects is in the top half of the possible range. The mean of the total scores for all the subjects is 20 points above the midpoint of the attainable range.

Part I of the scale scores for all the subjects shows a pattern similar to the total scores. The range of the Part I scores achieved is in the top half of the range of scores possible and the mean of the subjects' scores is 13.4 points above the midpoint of the possible range. The mean of the Part II scale scores is also above the midpoint of the possible range of scores for Part II (by 7.24 points). But, the achieved range of scores for Part II is not above the midpoint of the possible range of scores.

Table VI

Results of CTCP Scores for All Subjects (N=34)
Specialists and Generalists

Community Treatment of Chronic Psychiatric Patients Scale:

Total:	Range of Scores	100-146	(Possible Range 40-160)
	Mean of Scores	120.97	(Midpoint of possible range = 100)
	Standard Deviation	11.09	
Part I:	Range of Scores	44-69	(Possible Range 18-72)
	Mean of Scores	58.44	(Midpoint of possible range = 45)
	Standard Deviation	6.92	
Part II:	Range of Scores	49-77	(Possible Range 22-88)
	Mean of Scores	62.24	(Midpoint of possible range = 55)
	Standard Deviation	6.02	

CTCP Between group comparisons. Between subject-group comparisons for all four subject groups of the subjects' scores on the Community Treatment of Chronic Psychiatric Patients Scale is presented in Tables VII and VIII. Table VII comparisons of the specialist/setting versus generalist/setting groups' total scores show a comparable range of scores for both groups. The mean of the total scores of the generalist/setting group is 1.12 points higher than the mean of the total scores for the specialist/setting group. This finding is not significant at $p < 0.05$ with T-Test statistics.

Table VII
CTCP Between Group Comparisons:
Specialist/Setting versus Generalist/Setting

	Specialist/setting N=16			Generalist/Setting N=18				
	Range	x	SD	Range	x	SD	T-test	P
CTCP Total Score	101-136	120.38	10.18	100-146	121.50	12.10	F'=1.41	0.51
CTCP Part I	44-69	58.06	7.29	45-69	58.78	6.77	F'=1.16	0.76
CTCP Part II	52-69	62.31	4.33	49-77	62.17	7.33	F'=2.87 (17 & 15 DF)	0.05

Between group comparison of Part I scale scores shows the range for the two subject groups divided by setting to be similar. The mean for the generalist/setting group is 0.72 points higher than the specialist/setting group, but this finding is not significant at $p < 0.05$ with T-test statistics. Part II scale score comparisons show the most marked difference in the score ranges of the two setting groups and their standard deviations. The mean of the specialist/setting group is 0.14 points higher than the generalist/setting group of subjects. The T-Test administered to the data showed that this result is significant at the $p < 0.05$ level.

The between-group comparisons of the CTCP scores of the specialist/role group versus the generalist/role group are presented in Table VIII. The findings show that the range of the total scores and the standard deviations of the two groups are similar. The mean of the total scores of the specialist/role group is 2.69 points higher than the generalist/role group, but the T-Test shows no significance at the p 0.05 level. Part I scores of the scale show comparable results. The mean of the scores is 2.7 points higher for the specialist/role group than the generalist/role group. Again, this is not significant. Scores on part II of the scale show that the mean of the specialist/role group is 0.67 points higher than the generalist/role group. This is not significant according to T-Test results.

Table VIII
CTCP Between Group Comparisons:
Specialist/Role versus Generalist/Role

	Specialist/Role N=19			Generalist/Role N=15				
	Range	x	SD	Range	x	SD	T-test	P
CTCP Total Score	100-146	122.16	11.63	101-136	119.47	10.56	F'=1.21	0.72
CTCP Part I	45-69	59.63	6.98	44-67	56.93	6.77	F'=1.07	0.92
CTCP Part II	49-77	62.53	6.53	52-74	61.86	5.51	F'=1.40 (18 & 14 DF)	0.53

Discussion of CTCP between group comparisons. According to these results, the second hypothesis of the study, that the specialist subjects would score significantly higher on the Community Treatment of Chronic Psychiatric Patients Scale, was not confirmed. The only significant result related to the specialist/setting group scoring significantly higher on Part II of the scale. Therefore, it appears the subject group at the special center is more knowledgeable about the current research findings of community treatment of chronic psychiatric patients than the subject group at the other setting. One explanation of this finding is that there are more subjects with master's level professional training at the special center than at the community mental health center which has more mental health specialists. The better educated professionals may be more knowledgeable about research findings about community treatment of chronic patients, but the question remains whether this translates into more effective treatment practices. The majority of subjects, regardless of setting or role, perceived their treatment/service practices and attitudes (assessed in Part I of the CTCP) to be in keeping with what current literature reports is effective.

The between subject group comparisons of CTCP scores show very few significant results. This may have been caused by the limitations of the study and a lack of sufficient specificity in the operational definitions. The concept of chronic psychiatric patients implies that there is only one type of patient. Most likely, there are multiple differences among chronic patients; e.g., different personal characteristics, severity of social disability, residual psychiatric symptoms, etc. Additionally, the concept of the specialist role as originally defined by only the amount of time spent with chronic patients now appears sim-

plistic. A specialist requires specialized knowledge and merely possessing the title or working in a specialized area does not necessarily produce a specialist.

CMHI and CTCP Within group correlations. Within group correlations of the Community Mental Health Ideology Scale scores for all subjects and the Community Treatment of Chronic Psychiatric Patients Scale scores for all subjects are presented in Table IX. Very small positive correlations were found, but none are significant.

Table IX

Within Group Correlations - Specialists and Generalists

All Subjects (N=34) Specialists and Generalists

	Community Mental Health Ideology Scale
Community Mental Health Ideology Scale	r=1.000
Community Treatment of Chronic Psychiatric Patients Scale Total Score:	r=0.07759 p 0.66
Community Treatment of Chronic Psychiatric Patients Scale Part I:	r=0.05411 p 0.76
Community Treatment of Chronic Psychiatric Patients Scale Part II:	r=0.12579 p 0.48

Tables X and XI contain the within group correlations for the four subject groups. The specialist/setting subjects' scores for the Community Mental Health Ideology Scale correlate negatively with their Community Treatment of Chronic Psychiatric Patients Scale scores and Part II scores (Table X). The correlations are small and not significant at $p < 0.05$. The Part I scores for this subject group show almost no correlation with their Community Mental Health Ideology Scale scores. The generalist/setting subjects' Community Mental Health Ideology Scale scores correlate positively with their Community Treatment of Chronic Psychiatric Patients Scale total, Part I, and Part II scores. Although none of these correlations are significant at the $p < 0.05$ level, the correlation with Part II is the most suggestive.

Table X

Within Group Correlations

Specialist/Setting and Generalist/Setting

	Specialist/Setting CMHI	Generalist/Setting CMHI
Community Mental Health Ideology Scale (CMHI)	r = 1.000	r = 1.00
Community Treatment of Chronic Psychiatric Patients Scale Total Score: (CTCP)	r = -0.10181 p 0.71	r = 0.24094 p 0.34
CTCP Part I:	r = 0.00316 p 0.99	r = 0.11173 p 0.66
CTCP Part II:	r = -0.24468 p 0.36	r = 0.37403 p 0.13

The specialist/role subject group correlations show a comparable pattern as the generalist/setting group discussed. There are small positive correlations between the Community Mental Health Ideology Scale scores and the Community Treatment of Chronic Psychiatric Patients Scale total, Part I and Part II scores. None of the correlations are significant at the $p < 0.05$ level, but the correlation with part II is again suggestive. The generalist/role subject group correlations show a different pattern. The Community Mental Health Ideology Scale scores correlate negatively with the Community Treatment of Chronic Psychiatric Patients Scale total, Part I, and Part II scores. These negative correlations are relatively small and not significant at the $p < 0.05$ level.

Table XI

Within Group Correlations

Specialist/Role and Generalist Role

	Specialist/Role	Generalist/Role
	CMHI	CMHI
Community Mental Health Ideology Scale (CMHI)	r = 1.000	r = 1.00
Community Treatment of Chronic Psychiatric Patients Scale Total Score: (CTCP)	r = 0.34626 p 0.15	r = -0.31556 p 0.25
CTCP Part I:	r = 0.17154 p 0.48	r = -0.22220 p 0.43
CTCP Part II:	r = -0.43390 p 0.06	r = -0.27152 p 0.33

Regarding the within group correlations, interpretation of the results is difficult. The specialist/role and generalist/role subject groups showed the strongest trends to significant positive/negative correlations, but the meaning of these trends is unclear. Again, the limitations of the study, especially the uncertain reliability and validity of the scale developed by the investigator, may be at fault.

Conclusion and Recommendations

This exploratory study examined the complex area of the community service to the chronic mentally ill adult population by investigating the treatment ideology and the role of the mental health professional working with the chronic population. The adherence to community mental health ideology of the mental health professionals working with chronic psychiatric patients in two different community settings was compared. The settings utilized consisted of a community mental health center and a special service unit exclusively for chronic patients. The influence of the mental health professional's role, whether he functioned as a generalist with various types of patients or as a specialist with exclusively chronic patients, was explored.

The findings of the study show that community mental health ideology is strongly adhered to by all the subjects of the study, regardless of setting, role, or time spent working with chronic patients. With regard to the utility of a specialist role in the community service to the chronic mentally ill adult population, the study findings show that it makes no difference in the subjects' views of community treatment of chronic psychiatric patients as assessed by the CTCP scale developed by the investigator.

Based on this study, it can be concluded that mental health ideology is strongly adhered to by those mental health professionals delivering community service to chronic mentally ill adults. Additionally, setting and role designations do not necessarily support what they imply. Specialist settings do not always support specialist roles and generalist settings do not always support generalist roles.

The study findings are limited by several factors: the small sample size, an inadequate operational definition of specialist/generalist roles, the settings selected, and the instrument developed by the investigator to measure community treatment of chronic psychiatric patients. The small sample size (total N of 34) was problematic, particularly when the total was broken down into setting and role subgroups. The specialist role was defined too broadly, only in terms of the percentage of time spent working with chronic patients in the setting. In all likelihood, specialist and generalist roles need to be defined apart from their settings in terms of their own exclusive characteristics such as training or expertise. The settings selected had problems because a major attitudinal/administrative change occurred in one of them and they were not homogeneous, containing a mixture of specialist and generalist roles. Lastly, the reliability and validity of the instrument developed by the investigator is inadequate; a better measure of community treatment is needed.

Future research studies are recommended with a tighter study design, an improved measure of community treatment, and a larger sample to further investigate the influence of the specialist role in work with chronic psychiatric patients. Also, future studies are needed to verify the study finding regarding adherence to community mental

health ideology and to investigate the effectiveness of community mental health ideology in the services aimed at the deinstitutionalization of the chronic mentally ill.

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Appendix A

Baker-Schulberg
Community Mental Health Ideology Scale
and
Community Treatment of Chronic
Psychiatric Patients Scale

Code Number ...

BAKER-SCHULBERG CMHI SCALE

Instruction: Please read each of the statements carefully, in the order in which it appears, and for each one indicate to what extent you personally agree or disagree with it. You should do this by circling next to each statement the ***one of*** the six symbols which best represents your own feeling about the statement.

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

	Strongly agree	*Moderately agree*	*Slightly agree*	*Slightly disagree*	*Moderately disagree*	*Strongly disagree*	
1. Every mental health center should have formally associated with it a local citizen's board assigned significant responsibilities.	AAA	AA	A	D	DD	DDD	1
2. Our time-tested pattern of diagnosing and treating individual patients is still the optimal way for us to function professionally.	AAA	AA	A	D	DD	DDD	2
3. With our limited professional resources it makes more sense to use established knowledge to treat the mentally ill rather than trying to deal with the social conditions which may cause mental illness.	AAA	AA	A	D	DD	DDD	3
4. Our responsibility for patients extends beyond the contact we have with them in the mental health center.	AAA	AA	A	D	DD	DDD	4
5. A significant part of the psychiatrist's job consists of finding out who the mentally disordered are and where they are located in the community.	AAA	AA	A	D	DD	DDD	5
6. Such public health programs as primary preventive services are still of little value to the mental health field.	AAA	AA	A	D	DD	DDD	6
7. A mental health program should direct particular attention to groups of people who are potentially vulnerable to upsetting pressures.	AAA	AA	A	D	DD	DDD	7

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree	
8. The planning and operation of mental health programs are professional functions which should not be influenced by citizen pressures.	AAA	AA	A	D	DD	DDD	8
9. Mental health programs should give a high priority to lowering the rate of new cases in a community by reducing harmful environmental conditions.	AAA	AA	A	D	DD	DDD	9
10. The mental health specialist should seek to extend his effectiveness by working through other people.	AAA	AA	A	D	DD	DDD	10
11. A mental health professional can only be responsible for the mentally ill who come to him; he cannot be responsible for those who do not seek him out.	AAA	AA	A	D	DD	DDD	11
12. Our program emphasis should be shifted from the clinical model, directed at specific patients, to the public health model, focusing upon populations.	AAA	AA	A	D	DD	DDD	12
13. Understanding of the community in which we work should be made a central focus in the training of mental health professionals.	AAA	AA	A	D	DD	DDD	13
14. The control of mental illness is a goal that can only be attained through psychiatric treatment.	AAA	AA	A	D	DD	DDD	14
15. A mental health professional assumes responsibility not only for his current caseload but also for unidentified potentially maladjusted people in the community.	AAA	AA	A	D	DD	DDD	15
16. Our current emphasis upon the problems of individual patients is a relatively ineffective approach for easing a community's total psychiatric problem.	AAA	AA	A	D	DD	DDD	16
17. Our professional mandate is to treat individual patients and not the harmful influences in society.	AAA	AA	A	D	DD	DDD	17
18. Our efforts to involve citizens in mental health programs have not produced sufficient payoff to make it worth our while.	AAA	AA	A	D	DD	DDD	18

	Strongly agree	*Moderately agree*	*Slightly agree*	*Slightly disagree*	*Moderately disagree*	*Strongly disagree*	
19. The locus of mental illness must be viewed as extending beyond the individual, and into the family, the community, and the society.	AAA	AA	A	D	DD	DDD	19
20. Mental health professionals can be concerned for their patient's welfare only when having them in active treatment.	AAA	AA	A	D	DD	DDD	20
21. Mental health consultation is a necessary service which we must provide to community caregivers who can help in the care of the mentally ill.	AAA	AA	A	D	DD	DDD	21
22. Caregiving agents who worked with the patient before and during his contact at the mental health center should be included in the formulation of treatment plans.	AAA	AA	A	D	DD	DDD	22
23. A psychiatrist can only provide useful services to those people with whom he has direct personal contact.	AAA	AA	A	D	DD	DDD	23
24. Skill in collaborating with nonmental health professionals is relatively unimportant to the success of our work with the mentally ill.	AAA	AA	A	D	DD	DDD	24
25. The mental health center is only one part of a comprehensive community mental health program.	AAA	AA	A	D	DD	DDD	25
26. Mental health professionals should only provide their services to individuals whom society defines as mentally ill or who voluntarily seek these services.	AAA	AA	A	D	DD	DDD	26
27. We should deal with people who are not yet sick by helping them to develop ways for coping with expected life difficulties.	AAA	AA	A	D	DD	DDD	27
28. We should not legitimately be concerned with modifying aspects of our patient's environment but rather in bolstering his ability to cope with it.	AAA	AA	A	D	DD	DDD	28
29. It is a poor treatment policy to allow non-psychiatrists to perform traditional psychiatric functions.	AAA	AA	A	D	DD	DDD	29

	Strongly agree	*Moderately agree*	*Slightly agree*	*Slightly disagree*	*Moderately disagree*	*Strongly disagree*	
30. Since we do not know enough about prevention, mental health programs should direct their prime efforts toward treating the mentally ill rather than developing prevention programs.	AAA	AA	A	D	DD	DDD	30
31. The hospital and community should strive for the goal of each participating in the affairs and activities of the other.	AAA	AA	A	D	DD	DDD	31
32. Social action is required to insure the success of mental health programs.	AAA	AA	A	D	DD	DDD	32
33. In view of the professional manpower shortage, existing resources should be used for treatment programs rather than prevention programs.	AAA	AA	A	D	DD	DDD	33
34. Each mental health center should join the health and welfare counsel of each community it serves.	AAA	AA	A	D	DD	DDD	34
35. The responsible mental health professional should become an agent for social change.	AAA	AA	A	D	DD	DDD	35
36. We can make more effective use of our skills by intensively treating a limited number of patients instead of working indirectly with many patients.	AAA	AA	A	D	DD	DDD	36
37. By and large, the practice of good psychiatry does not require very much knowledge about sociology and anthropology.	AAA	AA	A	D	DD	DDD	37
38. Community agencies working with the patient should not be involved with the different phases of a patient's hospitalization.	AAA	AA	A	D	DD	DDD	38

COMMUNITY TREATMENT OF CHRONIC PSYCHIATRIC PATIENTS SCALE

This two part scale explores issues related to the community treatment (inpatient hospitalization and outpatient aftercare) of the chronic mentally ill population. Chronic psychiatric patients are defined as those adult individuals diagnosed as schizophrenic (DSM II/III), with a functional mental illness over one year's period of time, and having had more than one hospitalization for this illness. Aftercare is defined as post-hospital community treatment (e.g. half-way houses, board and care homes, out-patient clinic programs, day treatment, vocational rehabilitation, etc.)

IDENTIFYING DATA: Name of Facility Employed By_____

Age_____ Sex_____ Professional Discipline_____

Job Title_____ Years working at this job_____

Years working with chronic psychiatric patients_____

PERSONAL DATA: PLEASE CIRCLE ONLY ONE ANSWER.

1. What types of patients do you most prefer to work with?

   (a) personality disorders
   (b) affective disorders
   (c) organic disorders
   (d) first break schizophrenics
   (e) chronic schizophrenics
   (f) other Specify_____

2. What percentage of your time delivering treatment/service to patients involves chronic psychiatric patients?

   (a) 0 - 25 %
   (b) 25 - 50 %
   (c) 50 - 75 %
   (d) 75 -100 %

3. Have you had special training or education in treatment of chronic mental illness?

   (a) yes Specify:_____ (b) no

4. What are your feelings regarding working with chronic psychiatric patients?

   (a) work is frustrating (b) work is satisfying

PART I: Please circle one of the four symbols which is most descriptive of the actual treatment/service practices that exist at your facility for each of the following statements:

Circle AAA if the statement is strongly descriptive.

Circle AA if the statement is moderately descriptive.

Circle A if the statement is slightly descriptive.

Circle N if the statement is not at all descriptive.

1. At our service/treatment facility, chronic patients are always referred to aftercare treatments that meet their specific needs .....AAA AA A N

2. Our service/facility does not make an effort to provide continuity of care between hospital and community treatment (past and present) for its chronic patients.....AAA AA A N

3. Our service/facility does a meticulous review of the previous treatment history of its chronic patients to develop a comprehensive medication overview.....AAA AA A N

4. Issues of returning to the community not considered very important and therefore not addressed by our service/facility during the chronic patient's hospitalization.....AAA AA A N

5. At our service/facility we make a very definite effort to develop and refine our connections with community caregivers providing services to chronic patients.....AAA AA A N

6. Staff at our service/facility has not really developed a tolerance for chronicity in its psychiatric patients .....AAA AA A N

7. The staff at our service/facility knows very little about the resources that are available for chronic patients in the community ..AAA AA A N

8. At our service/facility we strongly emphasize tertiary prevention prevention (maintainence and rehabilitation) with our patients.....AAA AA A N

9. The most important goal of our service/facility is to serve those most in need (the sickest and least able to pay patients).....AAA AA A N

10. At our service/ facility we are valued as specialists, providing service to the patients who are the most chronic and difficult to treat.....AAA AA A N

11. When we work with chronic patients, we always feel that we are inept, bored, and wasting our talents.. .....AAA AA A N

12. At our service/facility, it is generally accepted that effective work with chronic patients requires only exceptional clinicians, not exceptional training .....AAA AA A N

13. At our service/facility, staff work very hard to help the chronic patient attain and maintain his best level of functioning.....AAA AA A N

14. At our service/facility we operate on the premise that if the chronic patient does not do well in the community, life at the state hospital may be better for him.....AAA AA A N

15. At our service/facility there exists very little commitment to training in skills for working with chronic patients.....AAA AA A N

16. Our service/facility always helps chronic patients with post-hospital planning for housing, finances, employment, leisure time activities, medication and psychiatric treatment.....AAA AA A N

17. At our service/facility we are valued professionally for academic pursuits, research, accurate diagnosis, and doing therapy.....AAA AA A N

18. Our service/facility has effective clinical leadership that is committed to the value of working with chronic patients in our community, rather than sending them to the state hospital.....AAA AA A N

PART II: Please circle one of the four symbols which indicates what you think about the validity (truth) of each of the following statements:

Circle AAA if the statement is strongly valid (truthful).
Circle AA if the statement is moderately valid (truthful)
Circle A if the statement is slightly valid (truthful).
Circle N if the statement is not at all valid (truthful).

1. In general, the longer a chronic patient stays in the hospital the better is his post-hospital adjustment (increased employment, decreased hospital readmission rate).....AAA AA A N

2. Improving the hospital treatment of chronic patients (by increasing staff/patient ratios, therapy time, appropriate medications) results in patient improvement and earlier discharge.....AAA AA A N

3. When the chronic patient's hospital treatment is improved an improvement in his post-hospital adjustment results (increased employment, decreased hospital readmission rate).....AAA AA A N

4. Hospitalization is a more effective way to treat acute episodes in chronic patients than community programs (day hospital, supportive residential settings, home follow-up visits).....AAA AA A N

5. Those chronic patients that participate in community treatment programs (day treatment, residential settings, outpatient clinics) end up spending more time in hospitals those that do not.....AAA AA A N

6. In general, there is no difference between hospital and community treatment in reducing psychiatric symptomatology in chronic patients.....AAA AA A N

7. The chronic patient's satisfaction with his treatment and life in general is greater when he is in the hospital rather than community treatment..... AAA AA A N

8. Acute symptoms of chronic patients generally increase during short-term hospitalization.....AAA AA A N

9. Short-term hospitalization usually results in extremely high rates of recidivism, poor community functioning, and poor quality of life for chronic patients.....AAA AA A N

10. Provision of aftercare increases recidivism in chronic patients in comparison to no aftercare.....AAA AA A N

11. In addition to providing interpersonal therapy, aftercare is more effective in keeping chronic patients on medications than no aftercare.....AAA AA A N

12. Psychotropic medications have a strong effect in reducing hospital readmissions in chronic patients, while therapy has a weak effect...AAA AA A N

13. Sociotherapy and medications together have a greater effect on reducing hospital readmissions in chronic patients than either one alone.....AAA AA A N

14. Individual therapy has a more positive effect than group therapy with chronic patients.....AAA AA A N

15. Chronic patients have a low drop-out rate for both individual and group outpatient therapy.....AAA AA A N

16. Neither group nor individual therapy is the treatment of choice for chronic patients.....AAA AA A N

17. Day treament for chronic patients (rather than outpatient clinic treatment) results in fewer hospital readmissions, less time in the hospital, less symptomatology, and higher employment .....AAA AA A N

18. Day treatment is more effective than outpatient clinic treatment for lower functioning chronic patients.....AAA AA A N

19. There is very little difference between the effectiveness of day treatment and outpatient clinic treatment for higher functioning chronic patients.....AAA AA A N

20. Outpatient clinic aftercare is more effective than a high input milieu aftercare model (day care, community lodge residential treatment) in reducing hospital time and making positive impacts on the psycho-social functioning of chronic patients.....AAA AA A N

21. Low expectancy environments (board and care homes) increase hospital readmissions rates more than high expectancy environments (day treatment, half-way houses, sheltered workshops) in chronic patients.....AAA AA A N

22. Low expectancy environments (board and care homes) usually have no effect on the psycho-social functioning of chronic patients, whereas, high expectancy environments (day treatment, half-way houses, sheltered workshops) have a positive effect.....AAA AA A N

COMMENTS:

COMMUNITY TREATMENT OF CHRONIC PSYCHIATRIC PATIENTS SCALE

This two part scale explores issues related to the community treatment (inpatient hospitalization and outpatient aftercare) of the chronic mentally ill population. Chronic psychiatric patients are defined as those adult individuals diagnosed as schizophrenic (DSM II/III), with a functional mental illness over one year's period of time, and having had more than one hospitalization for this illness. Aftercare is defined as post-hospital community treatment (e.g. half-way houses, board and care homes, out-patient clinic programs, day treatment, vocational rehabilitation, etc.)

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   (c) 50 - 75 %
   (d) 75 -100 %

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Circle AA if the statement is moderately descriptive.

Circle A if the statement is slightly descriptive.

Circle N if the statement is not at all descriptive.

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3. Our service/facility does a meticulous review of the previous treatment history of its chronic patients to develop a comprehensive medication overview.....AAA AA A N

4. Issues of returning to the community not considered very important and therefore not addressed by our service/facility during the chronic patient's hospitalization.....AAA AA A N

5. At our service/facility we make a very definite effort to develop and refine our connections with community caregivers providing services to chronic patients.....AAA AA A N

6. Staff at our service/facility has not really developed a tolerance for chronicity in its psychiatric patients .....AAA AA A N

7. The staff at our service/facility knows very little about the resources that are available for chronic patients in the community ..AAA AA A N

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9. The most important goal of our service/facility is to serve those most in need (the sickest and least able to pay patients).....AAA AA A N

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Circle AA if the statement is moderately valid (truthful)
Circle A if the statement is slightly valid (truthful).
Circle N if the statement is not at all valid (truthful).

1. In general, the longer a chronic patient stays in the hospital the better is his post-hospital adjustment (increased employment, decreased hospital readmission rate).....AAA AA A N

2. Improving the hospital treatment of chronic patients (by increasing staff/patient ratios, therapy time, appropriate medications) results in patient improvement and earlier discharge.....AAA AA A N

3. When the chronic patient's hospital treatment is improved an improvement in his post-hospital adjustment results (increased employment, decreased hospital readmission rate).....AAA AA A N

4. Hospitalization is a more effective way to treat acute episodes in chronic patients than community programs (day hospital, supportive residential settings, home follow-up visits).....AAA AA A N

5. Those chronic patients that participate in community treatment programs (day treatment, residential settings, outpatient clinics) end up spending more time in hospitals those that do not.....AAA AA A N

6. In general, there is no difference between hospital and community treatment in reducing psychiatric symptomatology in chronic patients.....AAA AA A N

7. The chronic patient's satisfaction with his treatment and life in general is greater when he is in the hospital rather than community treatment..... AAA AA A N

8. Acute symptoms of chronic patients generally increase during short-term hospitalization.....AAA AA A N

9. Short-term hospitalization usually results in extremely high rates of recidivism, poor community functioning, and poor quality of life for chronic patients.....AAA AA A N

10. Provision of aftercare increases recidivism in chronic patients in comparison to no aftercare.....AAA AA A N

11. In addition to providing interpersonal therapy, aftercare is more effective in keeping chronic patients on medications than no aftercare.....AAA AA A N

12. Psychotropic medications have a strong effect in reducing hospital readmissions in chronic patients, while therapy has a weak effect...AAA AA A N

13. Sociotherapy and medications together have a greater effect on reducing hospital readmissions in chronic patients than either one alone.....AAA AA A N

14. Individual therapy has a more positive effect than group therapy with chronic patients.....AAA AA A N

15. Chronic patients have a low drop-out rate for both individual and group outpatient therapy.....AAA AA A N

16. Neither group nor individual therapy is the treatment of choice for chronic patients.....AAA AA A N

17. Day treament for chronic patients (rather than outpatient clinic treatment) results in fewer hospital readmissions, less time in the hospital, less symptomatology, and higher employment .....AAA AA A N

18. Day treatment is more effective than outpatient clinic treatment for lower functioning chronic patients.....AAA AA A N

19. There is very little difference between the effectiveness of day treatment and outpatient clinic treatment for higher functioning chronic patients.....AAA AA A N

20. Outpatient clinic aftercare is more effective than a high input milieu aftercare model (day care, community lodge residential treatment) in reducing hospital time and making positive impacts on the psycho-social functioning of chronic patients.....AAA AA A N

21. Low expectancy environments (board and care homes) increase hospital readmissions rates more than high expectancy environments (day treatment, half-way houses, sheltered workshops) in chronic patients.....AAA AA A N

22. Low expectancy environments (board and care homes) usually have no effect on the psycho-social functioning of chronic patients, whereas, high expectancy environments (day treatment, half-way houses, sheltered workshops) have a positive effect.....AAA AA A N

COMMENTS:

Code Number .....

BAKER-SCHULBERG CMHI SCALE

Instruction: Please read each of the statements carefully, in the order in which it appears, and for each one indicate to what extent you personally agree or disagree with it. You should do this by circling next to each statement the *one of* the six symbols which best represents your own feeling about the statement.

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

	Strongly agree	*Moderately agree*	*Slightly agree*	*Slightly disagree*	*Moderately disagree*	*Strongly disagree*	
1. Every mental health center should have formally associated with it a local citizen's board assigned significant responsibilities.	AAA	AA	A	D	DD	DDD	1
2. Our time-tested pattern of diagnosing and treating individual patients is still the optimal way for us to function professionally.	AAA	AA	A	D	DD	DDD	2
3. With our limited professional resources it makes more sense to use established knowledge to treat the mentally ill rather than trying to deal with the social conditions which may cause mental illness.	AAA	AA	A	D	DD	DDD	3
4. Our responsibility for patients extends beyond the contact we have with them in the mental health center.	AAA	AA	A	D	DD	DDD	4
5. A significant part of the psychiatrist's job consists of finding out who the mentally disordered are and where they are located in the community.	AAA	AA	A	D	DD	DDD	5
6. Such public health programs as primary preventive services are still of little value to the mental health field.	AAA	AA	A	D	DD	DDD	6
7. A mental health program should direct particular attention to groups of people who are potentially vulnerable to upsetting pressures.	AAA	AA	A	D	DD	DDD	7

	Strongly agree	*Moderately agree*	*Slightly agree*	*Slightly disagree*	*Moderately disagree*	*Strongly disagree*	
8. The planning and operation of mental health programs are professional functions which should not be influenced by citizen pressures.	AAA	AA	A	D	DD	DDD	8
9. Mental health programs should give a high priority to lowering the rate of new cases in a community by reducing harmful environmental conditions.	AAA	AA	A	D	DD	DDD	9
10. The mental health specialist should seek to extend his effectiveness by working through other people.	AAA	AA	A	D	DD	DDD	10
11. A mental health professional can only be responsible for the mentally ill who come to him; he cannot be responsible for those who do not seek him out.	AAA	AA	A	D	DD	DDD	11
12. Our program emphasis should be shifted from the clinical model, directed at specific patients, to the public health model, focusing upon populations.	AAA	AA	A	D	DD	DDD	12
13. Understanding of the community in which we work should be made a central focus in the training of mental health professionals.	AAA	AA	A	D	DD	DDD	13
14. The control of mental illness is a goal that can only be attained through psychiatric treatment.	AAA	AA	A	D	DD	DDD	14
15. A mental health professional assumes responsibility not only for his current caseload but also for unidentified potentially maladjusted people in the community.	AAA	AA	A	D	DD	DDD	15
16. Our current emphasis upon the problems of individual patients is a relatively ineffective approach for easing a community's total psychiatric problem.	AAA	AA	A	D	DD	DDD	16
17. Our professional mandate is to treat individual patients and not the harmful influences in society.	AAA	AA	A	D	DD	DDD	17
18. Our efforts to involve citizens in mental health programs have not produced sufficient payoff to make it worth our while.	AAA	AA	A	D	DD	DDD	18

	Strongly agree	*Moderately agree*	*Slightly agree*	*Slightly disagree*	*Moderately disagree*	*Strongly disagree*	
19. The locus of mental illness must be viewed as extending beyond the individual, and into the family, the community, and the society.	AAA	AA	A	D	DD	DDD	19
20. Mental health professionals can be concerned for their patient's welfare only when having them in active treatment.	AAA	AA	A	D	DD	DDD	20
21. Mental health consultation is a necessary service which we must provide to community caregivers who can help in the care of the mentally ill.	AAA	AA	A	D	DD	DDD	21
22. Caregiving agents who worked with the patient before and during his contact at the mental health center should be included in the formulation of treatment plans.	AAA	AA	A	D	DD	DDD	22
23. A psychiatrist can only provide useful services to those people with whom he has direct personal contact.	AAA	AA	A	D	DD	DDD	23
24. Skill in collaborating with nonmental health professionals is relatively unimportant to the success of our work with the mentally ill.	AAA	AA	A	D	DD	DDD	24
25. The mental health center is only one part of a comprehensive community mental health program.	AAA	AA	A	D	DD	DDD	25
26. Mental health professionals should only provide their services to individuals whom society defines as mentally ill or who voluntarily seek these services.	AAA	AA	A	D	DD	DDD	26
27. We should deal with people who are not yet sick by helping them to develop ways for coping with expected life difficulties.	AAA	AA	A	D	DD	DDD	27
28. We should not legitimately be concerned with modifying aspects of our patient's environment but rather in bolstering his ability to cope with it.	AAA	AA	A	D	DD	DDD	28
29. It is a poor treatment policy to allow non-psychiatrists to perform traditional psychiatric functions.	AAA	AA	A	D	DD	DDD	29

	Strongly agree	*Moderately agree*	*Slightly agree*	*Slightly disagree*	*Moderately disagree*	*Strongly disagree*	
30. Since we do not know enough about prevention, mental health programs should direct their prime efforts toward treating the mentally ill rather than developing prevention programs.	AAA	AA	A	D	DD	DDD	30
31. The hospital and community should strive for the goal of each participating in the affairs and activities of the other.	AAA	AA	A	D	DD	DDD	31
32. Social action is required to insure the success of mental health programs.	AAA	AA	A	D	DD	DDD	32
33. In view of the professional manpower shortage, existing resources should be used for treatment programs rather than prevention programs.	AAA	AA	A	D	DD	DDD	33
34. Each mental health center should join the health and welfare counsel of each community it serves.	AAA	AA	A	D	DD	DDD	34
35. The responsible mental health professional should become an agent for social change.	AAA	AA	A	D	DD	DDD	35
36. We can make more effective use of our skills by intensively treating a limited number of patients instead of working indirectly with many patients.	AAA	AA	A	D	DD	DDD	36
37. By and large, the practice of good psychiatry does not require very much knowledge about sociology and anthropology.	AAA	AA	A	D	DD	DDD	37
38. Community agencies working with the patient should not be involved with the different phases of a patient's hospitalization.	AAA	AA	A	D	DD	DDD	38

Appendix B

Support Documents

UNIVERSITY OF CALIFORNIA - ALAMEDA COUNTY MENTAL HEALTH

INFORMATION SHEET FOR RESEARCH SUBJECTS

Study of the ideology of the mental health professional as a factor in the community service to the chronic mentally ill adult.

Purpose: The purpose of this study is the investigation of the relationship between community mental health ideology and the community treatment of chronic psychiatric patients. Additionally, the study explores the relationship between the role of the mental health professional and the community treatment of chronic patients& community mental health ideology.

Expectations: Participation in the study involves allowing Erika Madrid, graduate nursing student, to administer two written scales; the Baker-Schulberg Community Mental Health Ideology Scale and the Community Treatment of Chronic Psychiatric Patients Scale, to each subject.

The scales will be passed out and collected by the researcher and require no more than one-half hour of the subject's time to complete. The scales will be administered to the two groups of subjects in two separate group meetings (one at each of the research settings).

Risks and Benefits: The study may involve minimal risk to the subjects' psychological well-being, possibly generating concerns about the subjects' treatment/service to the chronic psychiatric patient population with which they have contact. The research study may benefit Alameda County Mental Health planners and administrators in determining treatment/service to the chronic mentally ill population in the county, but will be of no direct benefit to the subjects. The study does not compare agencies/facilities of the county, just roles of the mental health professionals.

Precautions to Minimize Risks: Names will not be recorded on the scales and the answers on the scales will only be used by the investigator in the analysis of data (anonymity of subjects maintained). The scales that contain the subjects' answers will be stored in a locked file cabinet in the UCSF School of Nursing, Department of Mental Health and Community Nursing. Alameda County Mental Health Services and the supervisors of the subjects will not have access to the subjects' answers on the scales but, they will receive information about the final research results. Participation in the research study is voluntary and will not affect the subjects' present or future employment status. The subjects can refuse to answer any question and can withdraw from the study at any time without jeopardy to employment status. The researcher has received permission from the Alameda County Mental Health Services Research Committee and the director of the subjects' clinic/service to conduct this research. The subjects receive no compensation for participation in the study.

Researcher: Erika Madrid 681-8080 ext.410 (8am-5pm, Mon-Fri)

SAN FRANCISCO
COMMITTEE ON HUMAN RESEARCH

June 16, 1980

Afaf Meleis, Ph.D.
Dept. of Mental Health & Community Nursing
N 505 Y

Dear Dr. Meleis:

During the meeting last week, as you know, the Committee on Human Research reviewed your new application, "Ideology of the Mental Health Professional as a Factor in the Community Service to the Chronic Mentally Ill Adult." The members agreed that the protocol could be approved contingent upon two modifications of the consent document.

Although the page to be given to prospective subjects is titled, "Consent to Act as a Research Subject," the form is not to be signed and is structured as an information sheet rather than a consent form. Thus, it should be re-titled.

It was also felt that the information given in the "Purpose" and "Expectations" sections of the form might tend to bias the subjects' responses, since it gives such a strong indication of what the investigators are expecting to find from the study. Perhaps parts of these sections could be re-written in more general terms regarding the aims of the study.

When four copies of your revised form have been received in 116 C and have been accepted, final approval will be issued. If you have any questions or objections, please call Erica Heath or Louise Tipton at extension 1814.

Sincerely,

James M. Lindauer, M.D.
Chairman
Committee on Human Research

LT

cc: Erika Madrid

June 16, 1980

TO: The Committee on Human Research

FROM: Erika Madrid, Graduate Nursing Student

Investigator

RE: Information Sheet for Subjects in the Study (Consent Form)

I have made some revisions, per the recommendations of the committee, on the consent form of my proposal. I have changed the title to information sheet and deleted some information. This information sheet will be passed out to each subject at the same time they receive the two scales to complete. It is for the subjects' use and may be retained by them. No written consents will be required of the subjects. The material in the information sheet will be discussed with the subjects prior to their receiving the actual sheet. The information sheet contains information on the purpose, expectations, risks and benefits, and precautions to minimize risks of the study.

Erika Madrid

Investigator

UNIVERSITY OF CALIFORNIA
SAN FRANCISCO
COMMITTEE ON HUMAN RESEARCH

TO: Afaf Meleis, Ph.D., for Erika Madrid
N 505 Y/3126 Wisconsin, Oakland, CA

RE: Ideology of the Mental Health Professional as a Factor in the Community Service to the Chronic Mentally Ill Adult

DATE OF APPROVAL: June 17, 1980

The UCSF Committee on Human Research has approved the above request to involve humans as subjects in research.

____ The submission was approved as submitted.

XX The submission was modified during review. Correspondence and modifications are available in the CHR office.

XX In addition to the above, approval is subject to the following condition(s):

NOTE: The chairman feels that subjects could not help but be biased by the information in the purpose section of the consent form. A less explicit purpose statement could inform potential subjects of the purpose without indicating the desired results.

APPROVAL NUMBER: 932307-01 This should be included on all correspondence, consent forms, and patient charts.

EXPIRATION DATE: June 17, 1981 If the project is to continue, it must be renewed by this date. Instructions are available.

MODIFICATIONS: Any modification affecting subjects must receive approval. Any deletion, including re-classification of any of the procedures to standard therapy, should be reported.

COMPLICATIONS: All complications must be reported immediately to the CHR.

NOTICE: The University will defend and indemnify any principal investigator in legal actions arising from research activities involving humans if the activities had current CHR approval.

QUESTIONS: If questions arise, please contact Erica Heath or Louise Tipton at (415) 666-1814 or at Clinics 116.

Sincerely,

James M. Lindauer, M.D.
Chairman
Committee on Human Research

CC: Contracts & Grants
Drug Information & Analysis Service

Enc: copies of submitted materials

June 4, 1980

TO: The Committee on Human Research

FROM: Erika Madrid, Graduate Nursing Student
Investigator

RE: Approval from Alameda County Mental Health Services for use of study settings.

I have submitted this proposal to the Alameda County Mental Health Services Research Committee to obtain their approval to conduct the research study in two of their treatment/service clinics. I have obtained verbal permission from this committee and the clinic directors and am waiting their written permission. When I obtain this permission I will forward a copy to the committee.

Thank you for your consideration.

Erika Madrid

Investigator

ALAMEDA COUNTY
HEALTH CARE SERVICES
· AGENCY
J. MICHAEL LEAHY, Agency Director

MENTAL HEALTH PROGRAM EVALUATION UNIT
285 - 17th Street
Oakland, California 94612
(415) 874-5035

June 23, 1980

Erika Madrid
3126 Wisconsin St.
Oakland, Ca. 94602

Dear Ms. Madrid:

As you know, the Research Committee met last week to review your proposal for research within the County's Mental Health Agency. The committee raised a number of technical issues regarding the proposal's research design, and it was decided that the review process could best be faciliated by an interview between the applicant and the committee. This meeting has been scheduled for June 27, at 9:30 a.m., at the second floor conference room, Oakland, California.

I have listed below the specific areas of concern raised by the committee, please review them and be prepared to discuss them at our meeting on Friday.

*The review of the literature does not appear to be either empirical or comprehensive.

*The study purpose is not clear or concise, the hypothesis or null-hypothesis is not presented in any organized format and correlations regarding effectiveness of treatments, improvements and outcomes are not justifiable under the study's current design.

*The methodological model requires additional organization and specificity; while the use of the "community ideology scale" as an dependent variable seems applicable, the applicability of the "community treatment scale" is highly questionable. This scale has not been adequately pre-tested and validated. Moreover, the specific questions listed in this scale appear to address issues more related to attitudes and knowledge than professional treatment abilities or experience.

*The research groups are not homogeneous. Many of the "specialist" have worked in "generalists" roles for most of their careers uptill recently. Furthermore, many "generalists" have a heavty caseload of chronic psychiatric patients.

*The "Pearsons R assumes interval level data, this is an weak assumption for the community treatment and ideology scales.

*Considering the different stage of development for each of the two scales any attempt to correlate them seems a methodological study at best.

*The proposal should distinctively clarify that client <u>outcomes</u> are not at issue in the study (the term "effective treatment" keeps coming up in the proposal). This is not appropriate in this particular study design.

*If subjects are aware of the research purpose and the specific scales to be used, this should be identified as a limitation.

*The research groups differ in many significant respects other than the range of clients they provide service (i.e. different center director, different billing requirements, physical location, program chiefs, and new unit vs. an established center, etc. . . .)

*Should the researcher have a particular bias toward one unit or the other (specialist vs. generalist) this should be stated or better controlled in the discussion interpretation and conclusion sections of the report than it is in the proposal.

*Part I of the community treatment scale should be treated as staff perception of their unit/centers program environment. Then any potential biases can also be identified or speculated about.

I hope that knowledge of these concerns will better equip you for our discussion on Friday.

Sincerely,

George Hightower

3126 Wisconsin Streeet
Oakland, California 94602
July 6, 1980

George Hightower, Chairman
Research Committee
Alameda County Health Care Services Agency
Mental Health Program Evaluation Unit
285 - 17th Street
Oakland, California 94612

Dear Mr. Hightower,

As we discussed at our meeting on June 27, 1980 with Dr. Frank Leiberman regarding the research committee's review of my research proposal, I have made some changes in my original proposal and am sending you a copy. The changes address the technical issues raised by the committee and enumerated in your letter of June 23, 1980. At our meeting on the 27th we decided on some compromises on how to address the technical flaws in the proposal. Since I have not received your letter clarifying these compromises, I have proceeded to address the issues from my notes on the compromises and have used your letter of the 23rd as a guide.

The main changes in my proposal consist of the following:

(1) more extensive background and review of literature information,

(2) clarification of the purpose of the study with the inclusion of the null-hypothesis and hypothesis; correlations regarding effectiveness of treatments, improvements and outcomes eliminated from the study design,

(3) "Community treatment scale" - clarification that it addresses issues related attitudes and knowledge rather than professional treatment abilities or experience; changes made in Part I of the scale to make this part more consistent ('my'changed to'our') and clarification that part I assess staff perceptions of their treatment environment,

(4) correlations using Pearsons R eliminated, and community treatment and ideology scales not correlated, and

(5) limitations section of the proposal expanded and various possible biases addressed; plus inclusion of a section on how possible intervening variables of the study (institutional and personal characteristics of the subjects/ service environments) will be addressed.

I hope that these changes in the proposal will make my study acceptable to the research committee and can obtain the approval of the committee so that I can proceed with the research data gathering. I will contact you next week regarding this matter.

Sincerely,

Erika Haasid

3126 Wisconsin Street
Oakland, California 94602
August 5, 1980

George Hightower, Chairman Research Committee
Alameda County Health Care Services Agency
Mental Health Program Evaluation Unit
285 - 17th Street
Oakland, California 94612

Dear Mr. Hightower,

Enclosed is the final copy of my research proposal to your research committee for your files. This proposal contains the five minor changes (on pages 6,7,8,11, and 15) that we discussed in our telephone conversation of 7/25/80. During this conversation you verbally conveyed to me the research committee's approval of my proposal, thereby enabling me to begin my data collection. I continue to await the committee's official written approval, as promised, in order to meet UC San Francisco required documentation procedures.

Sincerely,

Erika Madrid

ALAMEDA COUNTY
HEALTH CARE SERVICES
· AGENCY
J. MICHAEL LEAHY, Agency Director

MENTAL HEALTH PROGRAM EVALUATION UNIT
285 - 17th Street
Oakland, California 94612
(415) 874-5035

August 14, 1980

Ms. Erika Madrid
3126 Wisconsin St.
Oakland, CA 94602

Dear Ms. Madrid:

I am pleased to inform you that the Research Committee has conducted a technical review of your revised research proposal and is prepared to grant approval for research implementation. However, the committee raised some concerns around the items outlined below which will require minor modifications.

Item I, Significance of the Study (p. 6 & 7)

"The general benefits of this study relate to improving the community treatment of the chronic mentally ill population and thereby making the deinstitutionalization movement more successful. If the findings of this study show that community mental health ideology is not relevant to effective community treatment of chronic psychiatric patients, a new ideology with a different focus may be needed for mental health professionals to work successfully with this population."

Since this research examination is preliminary and exploratory in its design and focus, any implications or associations with the above underlined items are at best, subjective. Sound correlations with these items will necessitate a more extensive research design and focus.

Item II, Operational Definitions (p. 7)

"Part I of the scale (community treatment of chronic patients) assesses staff perceptions of treatment practices/attitudes at their facility . . . High score on part I indicates that the subjects perceive treatment practices/attitudes as consistent with those best suited to meet the needs of chronic patients . . . "

The underlined "high score" as referred to in this context as an operational definition, is relatively meaningless. A more suitable definition would indicate "statistically significant higher score or significantly higher score".

Item III, Hypotheses of the Study (p. 8)

(1) There will be a difference in the Baker-Schulberg Community Mental Health Ideology Scale scores between the specialist and the generalist subjects.

(2) There will be no difference in the Baker-Schulberg Community Mental Health Ideology Scale scores between the specialist and the generalist subjects.
(3) The specialist subjects will score higher on the Community Treatment of Chronic Patients Scale than the generalist subjects.
(4) There will be no difference in the Community Treatment of Chronic Psychiatric Patients Scale scores between the specialist and the generalist subjects.

The same situation exists here as described above with the operational definitions; in order for these hypotheses to be meaningful a more defined degree of difference is needed (i.e., significance or alpha level).

Item IV, Methods of Data Analysis

"The differences between the two groups of subjects (specialist and generalist) regarding community mental health ideology and community treatment of chronic psychiatric patients will be evaluated by the use of point-biserial correlation (T-test) statistics".

The Pearson 'R' statistic or point-biserial correlation assumes interval level data, which is a weak assumption for the community treatment and ideology scales. In this instance, a "T"-test for significance will suffice.

Item V, Plan for Maintaining Client and Agency Personnel Confidentiality

"The investigator contends that this study places the subjects only at minimal risk regarding their psychological well-being, possibly generating some concerns regarding whether or not they are providing effective treatment to their chronic psychiatric patients".

We have already established the point that this research examination is exploratory and any correlations are preliminary, therefore, the term effective as applied in this context is inappropriate.

It is the committee's judgement that consideration of these issues will strengthen the outcome and validity of your research proposal.

Should you have further questions, please phone me at your convenience.

Sincerely,

George Hightower, Chairman
Research Committee

GH:kr

cc: Frank Lieberman
Stan Taubman
Barbara Majak