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The Relationship between Selected Demographic Characteristics and Mental Health Board Members' Endorsement of Community Mental Health Ideology

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THE RELATIONSHIP BETWEEN SELECTED DEMOGRAPHIC CHARACTERISTICS
AND MENTAL HEALTH BOARD MEMBERS' ENDORSEMENT
OF COMMUNITY MENTAL HEALTH IDEOLOGY

by

Kathryn S. Thiel

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counseling and Personnel

Western Michigan University
Kalamazoo, Michigan
April 1980

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ACKNOWLEDGMENTS

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To my family and friends who gave support and encouragement throughout the project.

Kathryn S. Thiel
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CHAPTER I

INTRODUCTION

Ideology represents shared social meanings about events that enables individuals to carry out purposeful actions in the face of uncertain knowledge (Marx, 1969). Because of the lack of empirical knowledge about the etiology and treatment of mental disorders ideology serves as an important guide for conduct in the mental health field. Among the several mental health ideologies, community mental health is the newest and most rapidly growing treatment orientation. Its rapid growth is related to the establishment of a nationwide network of community mental health programs which provide the means for implementing community mental health concepts. However, the continuation of the services of these programs is frequently dependent upon the support of their respective community mental health program boards who are responsible for obtaining funding resources and developing program policies. The extent to which board members presently endorse community mental health concepts is not known. Considering the potential of this population to influence the future implementation of community mental health programs it seems essential to investigate the nature of their mental health treatment orientation.

Development of Community Mental Health Ideology

Mental health practitioners are faced with the situation of having insufficient empirically derived knowledge to meet the public
demand for effective mental health services. The responsibility for delivering mental health treatment without sufficient scientific knowledge to serve as a guide has created a climate for the development of multiple and competing treatment ideologies within the mental health field (Marx, 1969).

In the late 1950's several studies began to delineate the major treatment ideologies that were endorsed by mental health practitioners. Gilbert and Levinson (1957) identified "humanism" and "custodialism" as two opposing orientations to mental patients among hospital staff. Sharaf and Levinson (1957) found that mental health professionals with a humanistic orientation could be classified as having a psychotherapeutic or a sociotherapeutic treatment orientation. In a study of psychiatric services to New Haven residents Hollingshead and Redlich (1958) identified "analytic-psychotherapeutic" and "directive organic" as two other treatment orientations. Clarification of the ideological orientations of mental health practitioners was advanced by Strauss, Bucher, Ehrlich, and Sabshin (1964) when they integrated the somatic dimension identified by Hollingshead and Redlich with the psychotherapeutic dimensions proposed by Sharaf and Levinson. In a nationwide survey of hospital psychiatrists, Armor and Klerman (1968) found that somatotherapy, psychotherapy, and sociotherapy were independent treatment orientations. These authors predicted that the sociotherapeutic orientation would gain in ideological status in the clinical specialty of community psychiatry.

In the late 1960's Baker and Schulberg (1967) observed that community mental health had become another major treatment ideology of
the mental health field. In the process of developing a scale to measure individual commitment to community mental health Baker and Schulberg identified the concepts of this new treatment orientation as (a) professionals assuming responsibility for an entire population rather than an individual patient only, (b) primary prevention of mental illness through amelioration of harmful environmental conditions, (c) treating patients with the goal of social rehabilitation rather than personality reorganization, (d) comprehensive continuity of care for the mentally ill, and (e) total involvement of both professionals and nonprofessionals in the care of the mentally ill.

The emergence of community mental health as a major treatment orientation has been attributed to several historical factors. Scientific developments and social-political events combined to create a climate for endorsement of a community approach to mental health.

Within the mental health field there was a growing awareness of the ineffectiveness of treatment in large mental hospitals and an increased interest in social psychiatry. Advancements in chemotherapy made it possible for many mental patients to be released from hospitals and treated in outpatient settings.

Epidemiological studies of mental illness, which began in the 1930's, focused attention on the relationship between social factors and mental illness. Studies of mental illness on a community wide basis reported relationships between mental illness and a community's ecological patterns (Faris & Dunham, 1939), its social class structure (Hollingshead & Redlich, 1958), and its degree of integration and disintegration (Leighton, 1963). The findings of these and other
Community studies suggested that the incidence of mental illness could be reduced by altering a community's social structure.

The number of psychiatric casualties of World War II focused public concern on the magnitude of the problem of mental illness in this country. This concern was reflected in the enactment of the National Mental Health Act of 1946 and the Mental Health Study Act of 1955. The former act established the National Institutes of Mental Health, and the latter act created the Joint Commission of Mental Illness and Health to study the mental health needs of the country. The report of the Joint Commission recommended the development of programs that would return and maintain the mentally ill in their own communities, make psychiatric treatment more available to community members, and use non-medically trained mental health workers for selected psychotherapies (Joint Commission on Mental Illness and Health, 1960). These recommendations influenced the enactment of federal legislation in 1963 and 1965 that mandated funds for the development of community based mental health treatment centers. The development of a nationwide network of these centers provided the means for community mental health ideology to be operationalized.

In addition to the treatment and rehabilitation goals recommended by the Joint Commission a number of leaders in the mental health field advocated that community mental health programs should also focus on the primary prevention of mental illness (Bellak, 1964; Caplan, 1964; Dumont, 1968). Primary prevention has been defined by Caplan (1964) as "lowering the rate of new cases of mental disorder in a population over a certain period by counteracting harmful circumstances before

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they have a chance to produce illness" (p. 26). Counteracting harmful circumstances in a community called for expansion of the traditional treatment role of the mental health practitioner to include social actions. Social action was advocated as a major approach to primary prevention (Caplan, 1964) and included efforts to modify political and social policies with the aim of improving the plights of the poor and the ethnic minorities in a community. Arnhoff (1975) and Wagenfeld (1972) noted that endorsement of this concept of community mental health ideology was supported by the social climate of the 1960's which was characterized by widespread concern for the redress of social injustice through institutional reconstruction.

Although the concept of primary prevention has been a controversial aspect of community mental health ideology (Arnhoff, 1975; Dunham, 1967; Wagenfeld, 1972) it continues to be a value of the community mental health approach. The recent President's Commission On Mental Health, which was appointed in 1977 to study the mental health needs of the Nation, continued to endorse prevention as a mental health goal. In its final report the Commission included a strategy for prevention among its recommendations. However, the social action approach of the 1960's appears to have been modified in the Commission's recommendations for prevention activities. Its proposed prevention strategies were limited to treatment of children and promotion of primary prevention research.
Statement of the Problem

The study of ideology has traditionally been the concern of political sociology. Recently, interest in ideology has shifted from the study of political issues to other areas of psychological and sociological concern. Marx (1969) suggests that the primary contexts and referents of Western ideologies has shifted to occupational collectivities.

One occupational collectivity which has been a recent focus of ideological investigations is the mental health field. Studies of mental health treatment ideologies have found that practitioners' endorsement of a particular treatment ideology is related to their professional activities (Hollingshead & Redlich, 1958) and to the type of care given to patients in mental hospitals (Strauss et al., 1964).

Ideological investigation of community mental health as the newest treatment orientation of the mental health field has received considerable attention because endorsement of this approach has produced significant social changes which extend beyond the mental health profession. Arnhoff (1975) notes that community mental health has achieved such national prominence that it has influenced changes in social policy which affect a much larger spectrum of society than the mentally ill. Implementation of the community mental health approach has extended the responsibility of mental health practitioners beyond treatment of the mentally ill to treatment of social and political problems (Mechanic, 1969). The increased need for manpower to
implement community mental health programs has created new mental health professions and subspecialties, and the shifting of responsibility for the care of the mentally ill from mental institutions to the community has had a significant impact on community life (Arnhoff, 1975). Determination of the extent to which members of society continue to endorse community mental health concepts is one measure of the ability of the community mental health approach to maintain support for the social changes it has generated.

A series of empirical investigations of community mental health ideology was stimulated by the development of a scale by Baker and Schulberg (1967) that operationally measures personal commitment to community mental health concepts. These studies consistently found a strong endorsement of community mental health ideology among mental health practitioners. However, this endorsement was far from uniform and significant differences in level of endorsement were found among the various professional affiliations within the field (Baker & Schulberg, 1967; Langston, 1970; Wagenfeld, Robin, & Jones, 1974).

Other characteristics which were found to be related to the level of endorsement of community mental health ideology were level of education (Langston, 1970), socioeconomic background (Del Gaudio, Stein, Ansley, & Carpenter, 1975), geographic and organizational characteristics of community mental health centers (Wagenfeld et al., 1974), and individual personality characteristics (Penn & Baker, 1976).

Previous studies of community mental health ideology have primarily focused upon professionals associated with mental health and nonprofessional workers in community mental health centers. There is
little information available concerning the level of endorsement of community mental health concepts by populations outside the mental health field.

One population of particular interest is the citizen mental health board population. Information about this population's mental health treatment orientation has become increasingly important with the establishment of citizen boards that have administrative responsibilities for community mental health programs. It is the function of many of these boards to review the mental health needs of the community and to determine priorities for the allocation of funds to support local programs and services to meet these needs.

One study was reported which investigated the mental health treatment ideology of citizens serving on mental health boards. Baker and Schulberg (1969) investigated the relationship between personality characteristics of board members and their level of endorsement of community mental health ideology. The findings of this study indicated a strong endorsement of community mental health ideology by this population. However, the population of this study was confined to citizens which served on mental health advisory boards in eastern Massachusetts. These limitations prevent generalizing the findings of this study to mental health board members in other geographic areas and to mental health boards with administrative functions.

Since citizen boards have the potential to influence mental health programming in their communities, further investigation of the characteristics of this population and its acceptance of community mental health ideology is needed. Thus, this study addresses the
following problem question. What is the relationship between selected
demographic characteristics of community mental health board members
and their level of endorsement of community mental health ideology?

Purpose

The purpose of this study was to investigate the relationship
between selected demographic characteristics and the level of endorse­
ment of community mental health ideology by community mental health
board members. Analysis of this goal revealed three specific objec­
tives for this study.

1. Determination of the level of endorsement of community
mental health ideology by citizens serving on community mental health
boards.

2. Determination of the distribution of selected demographic
characteristics among citizens serving on community mental health
boards.

3. Determination if differences in demographic characteristics
of community mental health board members contributed to differences
in their level of endorsement of community mental health ideology.

Definition of Terms

Selected Demographic Characteristics

Selected demographic characteristics refers to eight demographic
variables which have been identified as having a significant relation­ship to endorsement of community mental health ideology among
previously studied populations. These variables are:

1. Age in years of the individual board member.

2. Length of board service as measured by the number of years the individual has served on the board.

3. Educational level of board members as measured by the education scale of the Two-Factor Index of Social Position (Hollingshead, 1957).

4. Social class background as measured by the social position of a board member's family of origin.

5. Medical school education as measured by board members' self-reports of their occupation being physician or medical doctor.

6. Nursing school education as measured by board members' self-reports of their occupation being registered nurse.

7. Length of a mental health board's existence as measured by the total number of years since it was initially funded by the state government.

8. Rural-urban complexity of the population served by a mental health board as measured by the percentage of a county or counties population that is defined as rural by the U.S. Bureau of Census.

Endorsement of Community Mental Health Ideology

Endorsement of community mental health ideology refers to the board members' scores on the Community Mental Health Ideology Scale (Baker & Schulberg, 1967). The scoring of this instrument is such that the higher the score the greater the endorsement of community mental health concepts.
**Community Mental Health Board**

Community mental health board refers to the organized group of citizens which has been appointed by a local government to administer funds for community mental health programs in a specific geographical area.

**Conceptual Framework**

Utilizing a sociological framework community mental health can be conceptualized as a social movement. Turner and Killian (1957) defined a social movement as "a collectivity acting in some continuity to promote or resist a change in the society or group of which it is a part" (p. 308). The salient features of a social movement are the existence of a shared ideology, a membership composed of leaders and followers, and a structure for promotion of the goals (Killian, 1964).

One could argue that community mental health has the essential features of a social movement. Baker and Schulberg (1967) have identified a community mental health treatment ideology which can be distinguished from other mental health treatment orientations. Studies which have investigated endorsement of this ideology substantiate the existence of a following among members of the mental health field (Baker & Schulberg, 1967; Langston, 1970; Wagenfeld et al., 1974). The national network of community mental health centers provide the structure to promote community mental health goals.
Killian (1964) proposed that social movement leadership can be classified as charismatic, administrative, or intellectual. The charismatic leader simplifies the ideology for the membership and symbolizes its values. The administrative leader promotes the ideology through development of strategies to obtain its goals. The intellectual leader elaborates and justifies the ideology. The intellectual leader represents a prestige figure whose writings are frequently cited by the members to support their positions and activities. The intellectual type of leadership in community mental health is exemplified by such prominent theorists as Bellak (1964), Caplan (1964), and Dumont (1968).

Ideology is the primary focus for investigation of social movements because it is the element that binds the members together and directs their activities. Heberle (1951) has proposed four levels of investigation of an ideology.

The first level is the analysis of the content of an ideology to identify its basic concepts. The initial work by Baker and Schulberg (1967) concentrated on this level of ideological investigation. In the process of development of a scale to measure commitment to community mental health ideology Baker and Schulberg identified the essential concepts of this ideology from an examination of community mental health literature. These concepts were then validated by a panel of nationally recognized experts in the field.

The second level of investigation involves tracing the history of an ideology and identifying the concurrent social events which influenced its development. This level is often combined with the
third level of investigation which is an analysis of an ideology's underlying assumptions about the nature of man and society. The works of Rossi (1962), Mechanic (1969), and Wagenfeld (1972) are examples of the second and third levels of ideological investigation in community mental health.

The fourth level of ideological investigation described by Heberle (1951) addresses the question of what makes the ideology appealing to its adherents. This question leads to an analysis of interest groups and social-psychological variables associated with individual endorsement of an ideology.

Previous studies of endorsement of community mental health ideology among the members of the mental health field have consistently found that professional affiliation is a predictor of acceptance of community mental health ideology (Baker & Schulberg, 1967; Langston, 1970; Wagenfeld et al., 1974). The finding that psychologists and social workers consistently have a significantly stronger endorsement of community mental health concepts than psychiatrists, nurses, and non-psychiatric physicians has led to the proposal that acceptance of community mental health ideology has less appeal to individuals with medical training.

Killian (1964) has theorized that a social movement will adopt one of two possible strategies for implementing its goals in a society. One strategy is societal manipulation which depends upon the exercise of power in the society to actualize its goals regardless of popular support. The other is conversion of numbers of societal members to their beliefs which is expected to lead to popular action in
support of the movement. The latter strategy is most likely to be adopted by social movements in a democratic society "where the mechanism for reform through popular action exists" (Killian, 1964, p. 449).

Community mental health programs are usually only partially funded by state and federal grants. Additional funding by the local community is required to maintain the programs. Since community mental health programs will be in competition with other community services for allocation of local funds they will need to rally citizen support for their particular services. A local citizen population which is instrumental in seeking and allocating funds for community mental health programs is the citizen mental health board. Thus, it is assumed that conversion of this population to community mental health ideology is essential to the community mental health movement.

This study will relate to the fourth level of ideological investigation proposed by Heberle (1951) and seek to identify social variables associated with acceptance of community mental health ideology by citizens serving on community mental health boards. Information is available concerning the social variables associated with acceptance of community mental health ideology by the members of the mental health field. However, this study contributes to the knowledge of community mental health ideology by providing information about the social variables associated with acceptance of community mental health ideology by a population of citizens outside the mental health field professional membership.
Importance of the Study

Determination of the level of endorsement of community mental health ideology among board members could have relevance as an indication of the extent to which community mental health has been accepted by individuals outside the mental health professions. Considerable public funds have been allocated for support of the development of community mental health programs. The governmental support of these programs is based on the belief that citizens will accept and support the community mental health approach to mental health care in this country.

The President's Commission on Mental Health (1978) has recently reinforced this belief with their recommendation that 275 million dollars should be appropriated for a new Federal grant program for community mental health services. The proposed purpose of this program is to: "encourage the creation of necessary services where none exist; supplement existing services where they are inadequate; and increase the flexibility of communities in planning a comprehensive network of services" (p. 18).

Citizen endorsement of the community mental health approach is an indication of their willingness to establish community mental health services in their communities and to provide ongoing support for their maintenance. Thus, the findings of this study could be of interest to legislators and government officials who are involved in planning legislation for the creation of new grant programs for community mental health services.
This study will also be of interest to community mental health professionals. The establishment of community mental health programs that have citizen boards with administrative as well as advisory functions has created a shift in the locus of control of community mental health programs (Balman, 1972). Mental health professionals who previously made policy decisions for local programs must increasingly share this function with citizens serving on community mental health boards. Professionals in community mental health administrative positions need to actively elicit the cooperation and support of their respective boards to promote the goals of community mental health in local programming. Balman (1972) notes that the extent to which citizens do not endorse community mental health concepts creates the potential for conflict between professionals and citizen groups.

The findings of this study could be of use to community mental health professionals who are involved in developing strategies for promoting citizen board support for their programs. Knowledge of the social variables associated with board member's endorsement of community mental health ideology could assist the professionals in planning promotion activities by delineating the boundaries of groups which are likely to support the community mental health approach and locating those socialization experiences which influence individual acceptance of community mental health ideology.

The results of this study could also be of interest to community mental health board members. Knowledge of the extent to which board members endorse community mental health concepts could assist the leadership faction of this population in assessing the need for the
development of in-service programs for their membership that would promote their understanding of the community mental health approach to mental health care.

This study will also contribute to the growing body of knowledge about the nature and influence of social movements in our society. Killian (1964) proposed that the study of the development and effects of social movements is one means of assessing the ability of human beings to deliberately create change in their own society. Mechanic (1969) has observed that mental health ideologies contribute to social change by their influence on the formulation of public policy. Arnhoff (1975) notes that when public policies are formulated on ideological issues the ideology tends to undergo a process of being granted validation by society irrespective of any empirical evidence. Once the social validation process has occurred it is difficult to change the direction of public programs derived from the ideology (Arnhoff, 1975). Widespread endorsement of the ideological concepts of a social movement is indicative that the social movement has become "institutionalized" as a desirable aspect of society that has a "legitimate function to perform in the larger society," and its ideological values have become incorporated into the wider system of cultural beliefs (Killian, 1964, p. 453).

Community mental health as a relatively new social movement provides an opportunity for sociologists to test and expand the theories of the relationships between social movements and social change. Determination of the level of endorsement of community mental health concepts among a population of citizens serving on community mental
health boards contributes to the assessment of the extent to which this ideology has been validated by society. Determination of the social characteristics of board members associated with their endorsement of community mental health ideology contributes to knowledge about the socialization experiences which influence individual acceptance of this ideology.
Baker and Schulberg (1967) observed that community mental health (CMH) represented a new social movement in mental health and that a growing collectivity of mental health professionals were beginning to share a common CMH treatment ideology. Postulating that this new treatment orientation could be distinguished from other mental health treatment orientations Baker and Schulberg (1967) developed the Community Mental Health Ideology Scale (CMHI Scale) to measure individual endorsement of CMH concepts.

The responses of 484 individuals representing various criterion groups of mental health specialists provided the initial data for tests of reliability and validity of the CMHI Scale. Findings from this criterion population indicated that adherence to CMH ideology was related to professional affiliation, age, work activities, and type of work setting. Significant differences were found between the mean scores for psychologists, psychiatrists, and occupational therapists with psychologists scoring the highest and psychiatrists the lowest. Total score correlations with age indicated that those supporting community mental health beliefs tended to be younger and had received their advanced training more recently than subjects with lower scores.
Respondents in the upper-scoring quartile spent a significantly greater proportion of their time in administration, consultation, and teaching than those in the lowest-scoring quartile. Respondents in the lowest-scoring quartile spent significantly more of their work week in direct patient care than respondents in the upper quartile. High scoring subjects tended to work in universities, general hospitals, or community clinics and school systems. Low scoring subjects tended to work in mental hospitals and private practice.

Since this initial work by Baker and Schulberg (1967), several studies have used the CMHI Scale to investigate correlates of commitment to CMH ideology. These studies have primarily focused upon professional and mental health worker populations.

Langston (1970) administered the CMHI Scale to 120 employees of two community mental health centers. The mean scores for professional affiliations were similar to those reported for comparable groups in the initial Baker and Schulberg (1967) study. A discrepant result between the two studies was Langston's finding that age was not significantly related to adherence to CMH ideology.

Significant relationships for level of education and length of time involved in a CMH center with CMHI Scale scores were additional findings of the Langston (1970) study. There was a positive, significant relationship reported between level of education and endorsement of CMH beliefs. This relationship was found for all professional affiliations except psychiatrists. Since there were other professional affiliations with a medically oriented education included in the study population, Langston concluded that medical school training
was unique in being associated with a lower degree of commitment to CMH ideology.

The finding of a significant relationship between length of time involved in a CMH center and endorsement of CMH ideology was interpreted by Langston (1970) as a function of association and communication between workers. The range of time for length of involvement was 1 month to 12 months. This rather limited time span seems insufficient for adequate testing of this variable as a correlate of endorsement of CMH beliefs.

Langston's (1970) study provided the first published data on CMHI Scale scores for social workers and nurses. These professional groups were not included in the initial Baker and Schulberg (1967) study. Nurses ranked fourth among the professional affiliations in their level of endorsement of CMH ideology.

Although the sample utilized by the Langston study was limited to the staff of only two centers located in the same city, the findings for levels of endorsement among professional affiliations were supported by a later study reported by Robin and Wagenfeld (1976) in which a sample of CMH center staff from a national sample of 20 centers was used. This consistency of findings not only provided evidence of the reliability of the CMHI Scale but indicates that socialization into the various professions is an influencing force in the determination of beliefs concerning mental health treatment.

Additional support for the influence of professional education on mental health beliefs was provided by a study conducted by Baker and Howard (1975). Their survey of the mental health treatment
orientations of a national sample of nurses enrolled in graduate programs in psychiatric nursing revealed that this population of nurses had a very high endorsement of CMH ideology. The mean CMHI Scale score for the nurses in this study ranked higher than most of the samples of professional disciplines in the Langston (1970) study, which included a sample of CMH center staff nurses. Since graduate degrees in clinical nursing specialties are relatively new and are not required for entry into the profession, differences in endorsement of CMH ideology between the graduate school nurses and the CMH center staff nurses could be attributed to the influence of advanced professional education in psychiatric nursing.

Del Gaudio et al. (1975) used the CMHI Scale to investigate the relationship between the socioeconomic background of 65 psychotherapists in an outpatient clinic and their adherences to CMH ideology. Hollingshead's (1957) Index of Social Position was used to calculate the socioeconomic status (SES) of the subject's family of origin.

Four professional disciplines; psychology, social work, nursing, and psychiatry were represented in the sample. Significant differences in mean CMHI Scale scores between these professional groups were found in essentially the same rank order as reported in the research by Langston (1970) and Robin and Wagenfeld (1976). These differences remained significant when SES background was held constant.

The findings for the socioeconomic status variable revealed that subjects from SES I scored significantly lower in commitment to CMH ideology than subjects from SES II through SES V backgrounds. This difference was also found within the psychiatry group and within the
other three professional groups combined. Differences between SES levels II through V were not significant. SES levels IV and V were combined in this study because of the small number of subjects in these categories.

The results of this study strengthened the observation that commitment to CMH concepts is in part a function of professional preparation. It also provided some indication that socioeconomic background is related to commitment to CMH ideology as measured by the CMHI Scale. The extent to which this finding can be generalized is limited by the relatively small sample and the confinement of its selection to one clinic population.

Penn, Baker, and Schulberg (1976) used the CMHI Scale to investigate the relationship between endorsement of CMH ideology and the personality preferences of 105 female social work students. The Edwards Personal Preference Schedule (EPPS) was used to survey the personality variables of the subjects. A comparison of scores on the 15 EPPS personality variables with extreme scores on the CMHI Scale revealed that the social work students who had a higher endorsement of CMH ideology had significantly lower needs for deference and order.

The restrictive nature of the study sample in terms of sex, profession, and educational setting limits the extent to which the findings can be generalized to other populations. However, the results provided some indication that endorsement of CMH ideology is partially a function of personality preferences.

Wagenfeld et al. (1974) compared the CMHI Scale scores of community mental health center workers with the organizational and catchment
Three catchment area characteristics were examined: socioeconomic status, ethnicity, and demographic complexity. Demographic complexity was the only catchment area characteristic which was found to be predictive of endorsement of CMH ideology. Defining demographic complexity as the nature and location of the population served five categories of demographic complexity were used: inner city, urban, rural, metropolitan mixed, and non-metropolitan mixed. The findings revealed that adherence to CMH ideology was significantly higher for staff from CMH centers serving an all rural population.

The organizational characteristic which was found to be significantly related to endorsement of CMH ideology was the auspice of the center. Auspice referred to the type of applicant applying for the center grant. Four types of auspices were delineated: Public/Governmental, Agency/Board, University Medical School, and Hospital. Staff whose centers were under University auspice had the strongest commitment to CMH ideology. Agency/Board ranked second in commitment followed by Hospital and Public/Governmental auspices. Since University auspices was an atypical situation, the data were recomputed omitting this category of center. Significant differences remained. Thus among the more common type of CMH center auspices Agency/Board auspice was a predictor of staff endorsement of CMH ideology.
Robin and Wagenfeld (1976) reported additional examination of the data from the study of community mental health worker roles. The CMHI Scale scores for the 595 CMH workers was compared with three different sets of variables.

The first set of variables included the personal characteristics of age and level of education. The findings were consistent with those reported by Langston (1970) for these variables. Age was not found to be significantly related to endorsement of CMH ideology. Higher levels of education were significantly associated with greater commitment to CMH beliefs for two of the professional affiliations, social workers and nurses.

The second set of variables examined the effect of center employment and experience upon ideology. These variables were measured by number of years employed at the center, percentage of time spent in direct services, and percentage of time spent in indirect services. Length of center employment was not related to ideological adherence. This finding was in contradiction to the results reported by Langston (1970) for this variable. The amount of time spent in Direct Service was inversely related to adherence to CMH ideology. The CMHI Scale scores decreased significantly in a linear manner with increasing amount of time in direct care of patients. The finding for amount of time spent in Indirect Services revealed a direct, significant relationship with higher CMHI Scale scores. Increasing involvement with the community in consultation and educational activities was strongly associated with greater adherence to the concepts of community mental health. These findings for type of service activity supported those
reported for this variable by Baker and Schulberg (1967).

The third set of variables dealt with dimensions of the worker's perceived professional role. Workers responses to vignettes illustrating community situations they might commonly encounter in their work were used to measure degrees of Personal/Professional Role Activism and Community Mental Health Center Role Activism. Differences between these two activism scores provided a measure of Role Discrepancy. Activism was defined as the "willingness to change the communities or social structures as a solution to the mental health problem presented in the vignette" (p. 339). The reported results indicated a significant relationship with endorsement of CMH ideology for only Personal/Professional Role Activism.

Utilizing a stepwise multiple regression analysis the authors reported that among the variables investigated, Personal/Professional Role Activism, Time Spent in Direct Services, and Time Spent in Indirect Services accounted for 19% of the variance in CMHI Scale scores. It was noted that variables related to personal aspects of the worker's role provided more explanation of the variance of ideological adherence than organizational aspects of the worker's role. The authors concluded that experience with CMH centers does not significantly contribute to mental health workers' endorsement of CMH ideology and that differences in level of endorsement are associated with factors related to personal characteristics, professional activities external to the center, and in experiences prior to center employment.
The results of an investigation of CMH ideology of the staff in a changing mental hospital (Baker & Schulberg, 1975) indicated support for the conclusions by Robin and Wagenfeld (1976). Baker and Schulberg administered the CMHI Scale to the staff of a large mental hospital before and 2 years after the hospital instituted a community mental health program. Although major program changes and personnel shifts had occurred at the hospital during this 2-year interval the group mean score for staff members completing both administrations of the CMHI Scale remained unchanged. A comparison of mean scores of the staff completing only the second administration of the scale revealed a significant increase in level of endorsement of CMH ideology. The authors interpreted this finding as an indication that individuals with a community mental health orientation were attracted to the new program during the 2-year interval and that those leaving the institution tended to view the new program as incompatible with their mental health orientation.

Two studies investigated the endorsement of CMH ideology among paraprofessionals employed in CMH centers. Paraprofessionals were defined as non-professionally trained individuals who were employed by CMH centers to work directly with clients.

Poovathamkal (1973) compared the CMHI Scale scores of 25 paraprofessionals from five different CMH centers with their length of employment in mental health treatment agencies and their age in years. Neither of these variables were found to be significantly related to their endorsement of CMH ideology.
Riley, Wagenfeld, and Robin (1976) examined the data for the sample of paraprofessionals from the study of community mental health worker roles by Robin and Wagenfeld (1974). Analysis of the CMHI Scale score data for this national sample of 95 paraprofessionals revealed that their level of endorsement of CMH ideology was positively related to their level of education. A comparison of the paraprofessionals with the samples of professional CMH workers revealed that the paraprofessionals endorsed CMH ideology at a lower level than the professional groups, except for the psychiatrists. The mean CMHI Scale score for the sample of paraprofessionals in the Riley et al. (1976) study was consistent with the mean CMHI Scale score for the sample of paraprofessionals in the Poovathamkal (1973) study.

Three studies were found in the literature that focused upon mental health board members as a study population. However, only one study investigated the endorsement of CMH ideology by a mental health board population. Baker and Schulberg (1969) administered the CMHI Scale, an abridged version of Rokeach's Dogmatism Scale and the Political-Economic Conservatism Scale, to 140 members of the Massachusetts Citizen Mental Health Area Boards. The results of the study indicated a relatively high endorsement of CMH ideology by this sample of board members. The reported mean CMHI Scale score was 219.1 which was higher than the mean obtained by the national samples of mental health professionals which formed the criterion data in the initial Baker and Schulberg (1969) study. The reported standard deviation was 26.3 and the range was 157-265. Thus there was considerable variability in level of ideological endorsement within the sample.
Part of this variance was explained by the significant intercorrelation found between CMHI Scale scores, Dogmatism Scale scores, and Political-Economic Conservatism Scale scores. Endorsement of CMH ideology was negatively associated with high degrees of dogmatism and adherence to conservative political principles.

Since the procedure for selection of subjects was not reported, it is not known to what extent the study sample represented the mental health board population. Thus the extent to which findings can be generalized to other mental health board members is limited.

Myers, Dowart, Hutcheson, and Decker (1974) also investigated the Massachusetts Mental Health Board Members. The objective of their study was to relate board members' attitudes toward their functioning and board characteristics with four categories of board accomplishment: Service Creation, Mobilization of Outside Resources, Local Autonomy, and Coordination. The total population of mental health board members of Massachusetts was included in the study. Data regarding board characteristics and accomplishments were obtained from the chairpersons of 37 mental health boards. Data about board members' attitudes were obtained from a mail questionnaire sent to 777 members which yielded 440 analyzable responses.

Although the Myers et al. (1974) study was not concerned with the mental health ideology of board members, certain findings are relevant to the present study. Length of board membership was significantly related to board accomplishment. It appears that members became more effective and active with increased experience in carrying out board activities that promoted mental health services in their
Obtaining information from fellow board members who were mental health professionals correlated significantly with board accomplishments. This finding indicates that professional members of mental health boards influence the attitudes and decisions of lay members of the boards.

Individual members' attempts to initiate programs and activities were also significantly related to board accomplishment. The authors concluded from this finding that the attitudes of individual members play an important role in shaping board activity. This finding also provides additional support for the importance of assessing the attitudes of board members regarding community mental health concepts.

Kupst, Reidda, and McGee (1975) compared attitudes toward mental health board functioning of the staff of 18 CMH centers in urban Chicago with the attitudes of the members of their citizen advisory boards. Data were collected from interviews with random samples of 30 staff members and 34 mental health board members.

This was the only study in the literature that reported demographic data regarding mental health board members. The data indicated that mental health boards in urban Chicago were composed of members that were predominately married males with a mean educational level of 15.8 years of school. The mean occupational category was managerial and proprietary positions. Twenty-one percent of the members were professionals. The mean number of years of residence in the community was 11.7 years. A comparison of these variables with degree of member activity on the board revealed no significant
Significant differences were found between the attitudes of center staff and board members regarding board functions. Board members saw their role as advisory and staff favored a more active involvement by board members in decision making.

Summary of Results of Previous Studies

Considering that the potential range of the CMHI Scale is 38-266, the mean scores reported for the various samples of mental health workers would indicate a general acceptance of community mental health concepts by this population. Baker and Schulberg (1967) reported mean scores ranging from 194.52 to 239.79 for their nine criterion groups. Langston (1970) reported mean scores for the professional subgroups of his sample that ranged from 202.38 to 235.89. Robin and Wagenfeld (1976) reported mean scores for professional subgroups ranging from 194.8 to 220.9.

However, two observations demand attention when drawing conclusions from these findings. Robin and Wagenfeld (1976) noted that "the lower potential range of the CMHI Scale far exceeds the actual range of scores found in research in which the scale is employed" (p. 339). The range of scores reported for the various samples indicate that while scores have been reported that fall within the upper quartile of the potential range, no reported scores have fallen within the lower quartile. This characteristic needs to be taken into consideration when interpreting findings based on scores for this instrument.
A second observation is the variability reported for the scores of subgroups. In the Robin and Wagenfeld (1976) study social workers scored the highest as a subgroup with a mean score of 220.9 and a standard deviation of 26.4. Psychiatrists scored the lowest with a mean score of 194.8 and a standard deviation of 31.0. Thus, there were subjects within one standard deviation in the lowest scoring group who scored at the mean of the highest scoring group. The standard deviations reported for professional affiliation subgroups in the Baker and Schulberg (1967) and Langston (1970) studies were similar in magnitude to those found in the Robin and Wagenfeld study. Although professional affiliation was consistently found to be a predictor of endorsement of CMH ideology there was considerable variability among members of the same professional group. Professional socialization appears to influence attitudes toward community mental health but the variability within professional groups would indicate that this influence is far from uniform.

There was less consistency among the research findings for other correlates of endorsement of CMH ideology. Baker and Schulberg (1967) reported age as significantly related to ideological endorsement. Investigations of this variable by Langston (1970) and Robin and Wagenfeld (1976) did not support this finding. Age was used as an indicator of the time at which the subjects received their professional education. It seems logical to assume that individuals who received their formal education during the 1960's when the social-political climate focused concern on social problems, would tend to support a social problem orientation toward mental illness. However,
age is a complex explanatory variable which can interact with many other variables. The discrepancy of the findings for age indicates that additional testing of this variable was warranted.

Level of education as a correlate of endorsement of CMH ideology also produced mixed results. Langston (1970) reported that increased education was significantly related to higher CMHI Scale scores. However, subjects who had attended medical school did not follow this pattern. Robin and Wagenfeld (1976) felt there was too much heterogeneity of this variable among professional affiliations to examine it for the total sample of CMH center staff and examined it for each professional grouping. Their findings indicated that level of education was significantly associated with ideological endorsement for social workers and nurses. There appears to be sufficient evidence that level of education is associated with endorsement of CMH ideology to warrant additional testing of this variable with a citizen board population.

Length of involvement with CMH centers was tested as a variable of ideological endorsement by Langston (1970), Poovathamkal (1973), and Robin and Wagenfeld (1976). Langston found a positive relationship for this variable while Poovathamkal and Robin and Wagenfeld found no significant relationship existed for their samples of CMH workers. This discrepancy in findings could be attributed to differences in length of time of involvement represented by the samples of the three studies. The staff members in the Langston study all had less than 1 year of involvement while the samples of workers in the Robin and Wagenfeld study had a range of 1 year to 5 years of
involvement, and the paraprofessionals in the Poovathumkal study had a range of 1 month to more than 10 years of involvement with mental health agencies. Since the nature of individual involvement with community mental health boards is considerably different from employment in a CMH center this variable was retested with a population of community mental health board members. The findings by Myers et al. (1974), that length of board membership was positively related to board accomplishment, could reflect a greater commitment to CMH beliefs among board members who continue to volunteer their services beyond their initial term of appointment.

The investigation by Del Gaudio et al. (1975) was the only study that investigated the relationship between socioeconomic background and endorsement of CMH ideology. Their finding, that within the same professional affiliation, subjects from Class I backgrounds had a significantly lower mean CMHI Scale score than subjects from other social class backgrounds suggests that endorsement of CMH ideology may partially be a function of social mobility.

Robin and Wagenfeld (1977) noted that one of the goals of the CMH movement was the redress of social inequities. This concern was initially focused on the imbalance in the mental health delivery system which favored the affluent upper classes. The development of the concept of primary prevention extended this concern to such large scale social inequity problems as poverty and racism (p. 7). It is possible that individuals who have experienced social class mobility have also experienced the effects of social class inequities and as a result are more supportive of the goals of the CMH movement.

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The investigations by Baker and Schulberg (1969) and Penn et al. (1976) were the only studies which examined the relationship between personality variables and endorsement of CMH ideology. Their findings indicated that endorsement of CMH ideology was negatively related to individual needs for order and deference and the personality trait of dogmatism. One explanation for these findings, offered by Penn et al. (1976) was that CMH ideology represented a break from traditional concepts of mental health treatment, and that it is the non-traditional characteristic of the ideology that could be appealing to individuals with low needs for deference and order and nondogmatic personality dispositions.

This explanation is consistent with the views of Rokeach (1960) concerning the relationship between ideology and personality. Rokeach proposed that individual belief systems had structural aspects as well as content. One structural aspect was the personality structure he labeled as "the phenomenon of ideological dogmatism" (p. 4) which could be associated with any ideology regardless of content. Dogmatism was defined as a "closed way of thinking" which is manifested in an authoritarian outlook on life and an intolerance toward those with opposing beliefs. The needs for deference and order as defined by Edwards (1959) could be related to dogmatism in that they could be manifested by intolerance for change from traditional modes of thinking and behaving.

The rapid expansion of CMH programs and the proliferation of literature regarding CMH concepts during the past decade may have generated sufficient familiarity to remove the CMH orientation from
the nontraditional category of mental health approaches. Additional testing of these personality correlates of CMH ideology is needed to determine if it is the nontraditional aspect of the ideology or the actual content of its concepts that is appealing to nondogmatic individuals and individuals low in deference and order needs. Killian (1964) noted that as a social movement progresses it attracts adherents to its ideology for whom acceptance of the concepts is more an "act of conformity that of protest" (p. 444). Thus the personality characteristics which differentiate the committed from the uncommitted in the early stages of the development of a social movement may not continue to serve this function as the movement gains in social acceptance and its ideology is incorporated into the values of the larger society.

The Wagenfeld et al. (1974) study was the only one which investigated the relationship between organizational variables of CMH centers and endorsement of CMH ideology. Their findings indicated that adherence to CMH ideology was highest among employees of CMH centers that served rural populations and were under Agency/Board auspices. One interpretation of the positive relationship between rural location and commitment to CMH ideology was the more clearly delineated sense of community and the relative paucity of alternative mental health services in rural area (Wagenfeld et al., 1974, p. 208). Since it is a function of CMH boards to address the mental health needs of their communities it is assumed that these factors would exert an influence on the ideological orientation of board members as well as mental health workers. Thus the number of rural residents served by a CMH
board was tested as a variable of board members' endorsement of CMH ideology.

The authors interpreted their finding of a positive relationship between Agency/Board auspices and adherence to CMH ideology as a function of decreased dependency upon medical leadership by this form of sponsorship. The medical and nursing professions consistently ranked lowest in commitment to CMH ideology in all the studies investigating professional affiliation as a variable of endorsement of CMH beliefs. The additional findings by Myers et al. (1974) that lay board members are influenced by the attitudes of professional board members suggests that the inclusion of members of the medical and nursing professions on community mental health boards could influence the lay board members' endorsement of CMH ideology. The findings of previous research would indicate that an inverse relationship exists between completion of medical school and nursing school education and endorsement of CMH ideology.

Baker and Schulberg (1975) noted that in order for an ideology to sustain support members of the movement must perceive that the goals embodied in the ideology are being met to some degree. If goals fail to be achieved, in time support for the ideology will wane. Thus the length of time that mental health boards have been functioning was tested as a variable of their adherence to CMH ideology. Boards that have been in existence longer would have had more time to establish programs and political influence that could test the success of their ideological orientation.
A review of previous research concerning community mental health ideology revealed that endorsement of this ideology by mental health workers is related to a number of variables. These variables include personal characteristics, past socialization experiences, and demographic characteristics of the population served. Eight variables were selected from these categories of characteristics for testing with a population of community mental health board members. These variables were: (a) age, (b) length of board service, (c) level of education, (d) social class background, (e) medical school education, (f) nursing school education, (g) years since a board was initially state funded, and (h) rural-urban complexity of the population served.

Hypotheses

This study addressed the problem of determining the relationship between selected demographic characteristics of community mental health board members and their level of endorsement of community mental health ideology. Eight demographic variables were selected as potentially being related to board members' endorsement of community mental health ideology. These variables were: (a) age, (b) years of board service, (c) level of education, (d) social class background, (e) medical school education, (f) nursing school education, (g) years since a board was initially state funded, and (h) rural-urban complexity of the population served. Examination of the literature pertaining to the study problem suggested the following hypotheses for these variables.
Hypothesis 1: Younger Community Mental Health Board members have a higher level of endorsement of community mental health ideology than older board members.

Hypothesis 2: The greater the number of years board members have served on the Community Mental Health Boards the higher their level of endorsement of community mental health ideology.

Hypothesis 3: Community Mental Health Board members with higher levels of education have a higher endorsement of community mental health ideology than board members with lower levels of education.

Hypothesis 4: Community Mental Health Board members from upper social class backgrounds have a lower endorsement of community mental health ideology than board members from lower social class backgrounds.

Hypothesis 5: Community Mental Health Board members who have completed a medical school education have a lower endorsement of community mental health ideology than board members who have not completed a medical school education.

Hypothesis 6: Community Mental Health Board members who have completed a nursing school education have a lower endorsement of community mental health ideology than board members who have not completed a nursing school education.

Hypothesis 7: The greater the number of years since Community Mental Health Boards were initially funded by the state the higher the level of endorsement of community mental health ideology by their board members.

Hypothesis 8: Members of Community Mental Health Boards that serve a predominately rural population have a higher level of
endorsement of community mental health ideology than members of Community Mental Health Boards that serve a predominately urban population.

Limitations and Assumptions

The findings of this study are limited to the population of Community Mental Health Board members in the state of Michigan. Community Mental Health Boards in other states may be operating under different state legislation which affects their organization, responsibilities, and boundaries of jurisdiction. These differences would limit the extent to which the findings of this study can be generalized to other community mental health board populations.

The use of a mail questionnaire may introduce bias into the study that should be taken into consideration when interpreting its findings. Kerlinger (1973) noted that the principal disadvantage of the mail questionnaire is the low rate of return which may produce a biased sample. Although 65.5% of the study population returned unusable questionnaires, the self-selected nature of this sample limits the extent to which the findings can be generalized to the board members in the study population that did not participate in the study.

It was assumed in this study that citizens serving on community mental health boards hold specific beliefs about the etiology and treatment of mental illness and that these beliefs could be assessed by their responses to the Community Mental Health Ideology Scale.
CHAPTER III

DESIGN OF THE STUDY

The purpose of this study was to investigate the relationship between selected demographic characteristics and the level of endorsement of community mental health ideology by community mental health board members. Since the study was seeking to ascertain relationships between social variables and attitudes in a selected population the comparative survey method of research was used.

Study Population

The study population consisted of citizens serving on county community mental health program boards in the state of Michigan. At the time of the study there were 55 county community mental health boards distributed throughout the state. Each board is composed of 12 county residents appointed by the county's board of commissioners. Four of the boards reported a vacancy which resulted in a total of 656 county community mental health board members at the time of the investigation.

The Michigan Mental Health Code (1977) defines the organizational framework of the community mental health boards in terms of their size, method of selection, term of appointment, powers, and duties. Thus the Michigan Community Mental Health boards provided a sizable population of citizens' boards that are similar in organizational characteristics. It was assumed that this consistency in organizational
characteristics would reduce the amount of variability in outcome measures that could be due to differences in board organization factors.

Data Collection Procedure

A roster of the names and addresses of board members was obtained from each of the 55 county community mental health boards. A questionnaire accompanied by a cover letter was mailed to each board member. In addition to questions eliciting demographic information the questionnaire included the 38 items of the Community Mental Health Ideology Scale (CMHI Scale).

An initial mailing of questionnaires to 656 board members resulted in a return rate of 56.7% (N = 372). A second mailing to 284 of the nonrespondents had a 20.4% return rate (N = 58). A total of 430 usable questionnaires were returned. This sample represented 65.5% of the board population.

Data for eight demographic variables were collected for comparison of board members' CMHI Scale scores. Data for age, level of education, completion of medical education, completion of nursing education, years of service on the board, and social class background were obtained from respondents' self-reports on the questionnaires. Data for the number of years since a board was initially state funded was obtained from the public records of the Michigan Department of Mental Health. Data for the rural-urban complexity of the population served were obtained from the U.S. Census of Population Report of the Urban and Rural Population of Michigan Counties (Verway, 1976).
Study Sample

Usable questionnaires were returned by 65.5% (N = 430) of the community mental health board population. Comparison of the respondents with the total board population by sex, rural-urban complexity of the population served, and years since their boards were initially state funded did not reveal any substantial differences. Thus the respondents were a representative sample of the board population in these demographic characteristics. The distribution by sex, rural-urban complexity, and years since initially state funded for the study sample and the board population are presented in Tables 1, 2, and 3.

Table 1
Distribution by Sex for Board Population and Study Sample

<table>
<thead>
<tr>
<th>Sex</th>
<th>Board Population</th>
<th>Study Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td>Females</td>
<td>256</td>
<td>39</td>
</tr>
<tr>
<td>Males</td>
<td>400</td>
<td>61</td>
</tr>
</tbody>
</table>

The median and modal age range of the study sample was 45 years to 54 years with 88% of the respondents reporting their age as over 35 years.

The median educational level was 4 years of college and the modal educational level was graduate school. There were 85% of the respondents who reported having formal education beyond high school.
Table 2
Distribution by Rural-Urban Complexity for Board Population and Study Sample

<table>
<thead>
<tr>
<th>Percent rural</th>
<th>Board population</th>
<th>Study sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td>0-24</td>
<td>83</td>
<td>12.7</td>
</tr>
<tr>
<td>25-49</td>
<td>143</td>
<td>21.8</td>
</tr>
<tr>
<td>50-74</td>
<td>251</td>
<td>38.2</td>
</tr>
<tr>
<td>75-100</td>
<td>179</td>
<td>27.3</td>
</tr>
</tbody>
</table>

Table 3
Distribution by Years Since a Board Was Initially State Funded for Board Population and Study Sample

<table>
<thead>
<tr>
<th>Years since funded</th>
<th>Board population</th>
<th>Study sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td>3-5</td>
<td>95</td>
<td>14.5</td>
</tr>
<tr>
<td>6-8</td>
<td>143</td>
<td>21.8</td>
</tr>
<tr>
<td>9-11</td>
<td>59</td>
<td>9.2</td>
</tr>
<tr>
<td>12-14</td>
<td>359</td>
<td>54.5</td>
</tr>
</tbody>
</table>

The median and modal years of service on the board were 1-3 years. There were 17% of the respondents who had served less than 1 year on their board and 22% who had served more than 6 years on their board.
The majority of respondents (67%) were members of boards that served populations that were over 50% rural. There were 11% of the respondents that were members of boards serving a 100% rural population and 5% of the respondents that were members of boards serving populations that were less than 10% rural. The study sample proportions for the rural-urban complexity of the populations served were consistent with those for the board population.

The occupations of respondents varied widely. The most frequently reported occupations were business manager (12%), housewife (11%), educator (8%), and educational administrator (7%). Other frequently reported occupations were attorney (5%), clergy (5%), physician (5%), and registered nurse (4%). There were 10% of the respondents who reported they were retired.

Measurement of Variables

Rural-urban complexity was measured by the percentage of the population of the county or counties served by a board that was defined as rural by the U.S. Bureau of the Census (1970). Four levels of rural-urban complexity were used for analysis: urban (0-24% rural), urban-rural mix (25-49% rural), rural-urban mix (50-74% rural), and rural (75-100% rural).

Ordinal measures were also used for educational level and social class background. The ranking of these variables was determined by the scales of the Two-Factor Index of Social Class Position.

The variable on which the demographic variables were analyzed was the CMHI Scale scores. Since the items of this instrument are
arranged on a Likert-type scale it was assumed that the resulting scores were based on interval level of measurement.

Community Mental Health Ideology Scale

The CMHI Scale was developed by Baker and Schulberg (1967) to measure individual commitment to community mental health concepts. These concepts were identified by Baker and Schulberg as (a) concern for the entire population of both identified and unidentified potentially sick members of the community, (b) primary prevention activities designed to counteract harmful forces before they had a chance to produce illness, (c) treatment goals designed to achieve social adjustment rather than personality reconstruction, (d) continuity of professional responsibility within an integrated network of caregiving agencies, and (e) the involvement of other community caregivers in the care of the mentally ill with the view that the mental health specialists can extend their effectiveness by working through and with others.

Nine criterion groups of mental health specialists were used in the development of the scale. It is composed of 38 items which were retained from a larger item pool by principal-components factor analysis. Thus the CMHI Scale is unifactorial by design. Even when items from the CMHI Scale were embedded within a larger, similar scale they continued to have a unifactorial character (Bloom & Parad, 1977).

The items are arranged in a seven point Likert format. Scoring was carried out in accordance with the procedure recommended by Baker and Schulberg (1967). Using this procedure the potential range of
scores is 38 to 266. The higher scores indicate a greater degree of commitment to community mental health ideology.

The CMHI Scale was reported by Baker and Schulberg (1967) to have a corrected split-half reliability coefficient of .95, a Cronbach Alpha (Kuder-Richardson Formula 20) of .94, and a test-retest reliability of .92. The corrected split-half reliability coefficient for the sample of board members in this study was .92.

Application of the CMHI Scale by Langston (1970), Poovathamkal (1973), Wagenfeld et al. (1974), Baker and Schulberg (1975), and Del Gaudio et al. (1975) indicates that it is sensitive to mental health ideology patterns and discriminates among mental health professionals and workers. In a study of the value orientations of the staff of 55 community mental health centers, Bloom and Parad (1977) incorporated eight of the CMHI Scale items into a larger scale of mental health value orientations. They reported that the CMHI Scale items continued to discriminate differences in attitudes among mental health professionals even when incorporated in another scale.

Two-Factor Index of Social Position

The Two-Factor Index of Social Position was utilized to measure the variables, level of education and social class background. This index, which was developed by Hollingshead (1957), uses the factors of occupation and education to estimate the social position of individuals.

The occupational scale is premised upon the assumption that occupations have different values attached to them by members of society.
(Hollingshead, 1957, p. 8). It has seven categories of positions arranged in descending order of social value. The higher scores represent occupations with lower social value.

The educational scale is premised upon the assumption that individuals with similar levels of education have similar tastes and attitudes and tend to exhibit similar behavior patterns (Hollingshead, 1957, p. 9). It is divided into seven positions arranged in descending order of amount of formal schooling. Higher scores represent lower levels of education.

The index of social position is obtained by combining the weighted scores for Occupation and Education. Occupation has a factor weight of 7 and Education has a factor weight of 4. Social Position Scores may be arranged on a continuum, with a possible range of 11 to 77, or divided into groups of scores. Five social class positions are used for grouping of scores.

Unweighted scores were used for measurement of the educational level of board members in this study. Weighted scores were calculated for estimation of the social class background position of board members. Social class background position scores were divided into the five social class position groups for data analysis procedures.

Analysis of Data

The unit of analysis was individual board members. Descriptive statistics were obtained for each of the study variables. Differences between mean CMHI Scale scores for subgroups of respondents were analyzed with the t-test for differences between independent
means and analysis of variance procedures. The Scheffe method of multiple comparisons (Glass & Stanley, 1970) was used to isolate comparisons between means when the null hypothesis of no difference between means in analysis of variance was rejected.
CHAPTER IV

ANALYSIS OF RESULTS

Usable questionnaires were returned by 65.5% of the Michigan Community Mental Health Board members which resulted in a sample size of 430 board members. A comparison of the respondents with the board population by sex, number of years since their boards were initially state funded, and rural-urban complexity of the population served indicated that the study sample was representative of the board population in these demographic variables.

Analysis of Respondents by Time of Return

Data for the respondents were analyzed by time of return. Return Group 1 represented the board members who responded to the initial mailing of questionnaires in 14 days. Return Group 2 represented the board members who responded to the initial mailing of questionnaires after the 14th day. Return Group 3 were board members who responded to the second mailing of questionnaires. The CMHI Scale scores data for the three return groups is presented in Table 4.

Since the difference between the mean CMHI Scale scores for Return Groups 1 and 2 was negligible these groups were combined for testing of differences between the mean CMHI Scale scores for the first mailing respondents and the second mailing respondents. A random sample of 58 observations was selected from the first mailing respondents to equalize the size of the two respondent samples. The
sample sizes were equalized to compensate for the heterogeneity of variances of the two groups (Glass & Stanley, 1970, p. 297). The CMHI Scale score data for the randomly selected sample of the first mailing respondents and the second mailing respondents are presented in Table 5. A t-test for differences between the mean scores of the first and second mailing respondents resulted in a $t$ value of 2.714 which had a .008 probability of occurrence.

Table 4
CMHI Scale Score Data for Return Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>300</td>
<td>201.4</td>
<td>25.78</td>
<td>116-259</td>
</tr>
<tr>
<td>2</td>
<td>72</td>
<td>200.4</td>
<td>27.50</td>
<td>138-258</td>
</tr>
<tr>
<td>3</td>
<td>58</td>
<td>190.4</td>
<td>21.07</td>
<td>137-246</td>
</tr>
</tbody>
</table>

Table 5
CMHI Scale Score Data for First Mailing Respondents and Second Mailing Respondents

<table>
<thead>
<tr>
<th>Mailing</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>58*</td>
<td>202.3</td>
<td>26.14</td>
</tr>
<tr>
<td>2nd</td>
<td>58</td>
<td>190.4</td>
<td>21.07</td>
</tr>
</tbody>
</table>

*Randomly selected sample of all first mailing respondents

$t (114) = 2.71, p = .008$
The CMHI Scale scores were analyzed for interaction between time of return and the demographic variables; sex, age, years of board service, educational level, social class background, and rural-urban complexity of the population served. Two-way analysis of variance between the first and second mailing respondents and each of these demographic variables did not produce any F-ratios that were significant at the .05 level of probability. Thus differences in the mean CMHI Scale scores for the first and second mailing respondents were independent of any differences in distribution of the demographic variables of this study.

CMHI Scale Scores

The total sample of respondents had a mean CMHI Scale score of 199.77 with a standard deviation of 25.71 and a range of 116 to 259. The median was 200.50 and the modal score was 189. The 1st quartile was 183.48 and the 3rd quartile was 219.23. The semi-interquartile range was 17.87.

Age

There were 427 respondents who indicated their age range on the questionnaire by checking one of the six categories for age in years. Since only one respondent indicated an age of less than 25 years this age category was excluded from the comparison procedure. The CMHI Scale score data for age levels are presented in Table 6.

It was hypothesized that there would be a difference between the mean CMHI Scale scores for the different age groups. The difference
between the mean CMHI Scale scores for the five age categories was tested at the .05 level of significance with a one-way analysis of variance. The resulting $F$ ratio of .1785 with 5 degrees of freedom had a .97 probability of occurrence. The hypothesis that there is a difference between the mean CMHI Scale scores for the different age groups of board members was not supported by the data.

Table 6
CMHI Scale Score Data for Age Levels

<table>
<thead>
<tr>
<th>Age in years</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-34</td>
<td>48</td>
<td>201.8</td>
<td>25.38</td>
<td>140-242</td>
</tr>
<tr>
<td>35-44</td>
<td>89</td>
<td>200.6</td>
<td>26.17</td>
<td>122-250</td>
</tr>
<tr>
<td>45-54</td>
<td>117</td>
<td>198.5</td>
<td>26.92</td>
<td>116.258</td>
</tr>
<tr>
<td>55-64</td>
<td>103</td>
<td>200.7</td>
<td>22.64</td>
<td>144-247</td>
</tr>
<tr>
<td>65+</td>
<td>59</td>
<td>198.7</td>
<td>28.59</td>
<td>137-259</td>
</tr>
</tbody>
</table>

$F (5) = .178, p = .97$

Years of Board Service

There were 396 respondents who indicated their length of service on their mental health board by checking one of the five categories of years of board service. The median and modal category of years of service was 1-3 years. The CMHI Scale score data for years of board service are presented in Table 7.

It was hypothesized that there would be a difference between the mean CMHI Scale scores for the categories of years of service on the
mental health boards. The difference between the mean CMHI Scale scores for the five categories of years of service was tested at the .05 level of significance with a one-way analysis of variance. The resulting $F$ ratio of .8455 with 4 degrees of freedom has a .497 probability of occurrence. The hypothesis that there is a difference between the mean CMHI Scale scores for the categories of years of service on mental health boards by board members was not supported by the data.

Table 7
CMHI Scale Score Data for Years of Board Service

<table>
<thead>
<tr>
<th>Years of service</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1</td>
<td>67</td>
<td>202.9</td>
<td>27.05</td>
<td>138-250</td>
</tr>
<tr>
<td>1-3</td>
<td>135</td>
<td>197.1</td>
<td>25.23</td>
<td>116-250</td>
</tr>
<tr>
<td>4-6</td>
<td>109</td>
<td>201.9</td>
<td>25.70</td>
<td>122-257</td>
</tr>
<tr>
<td>7-9</td>
<td>44</td>
<td>200.1</td>
<td>25.91</td>
<td>144-258</td>
</tr>
<tr>
<td>10 or more</td>
<td>41</td>
<td>202.0</td>
<td>24.52</td>
<td>155-259</td>
</tr>
</tbody>
</table>

$F (4) = .845, p = .497$

Education

There were 428 respondents who indicated their level of education on the questionnaires by checking one of seven categories of education. The levels of education were: (a) graduate school, (b) 4 years college, (c) 1-3 years college or vocational program, (d) high school, (e) 1-3 years high school, (f) junior high school, and (g) less than
7 years of school. The median educational level was 4 years of college and the modal educational level was graduate school. Since only seven respondents indicated they had completed less than a high school education, Levels e, f, and g were excluded from the analysis procedures. The CMHI Scale score data for educational levels are presented in Table 8.

Table 8

<table>
<thead>
<tr>
<th>Level</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate school</td>
<td>197</td>
<td>203.6</td>
<td>26.35</td>
<td>137-258</td>
</tr>
<tr>
<td>4 years college</td>
<td>73</td>
<td>202.0</td>
<td>20.45</td>
<td>138-246</td>
</tr>
<tr>
<td>Partial college</td>
<td>93</td>
<td>196.8</td>
<td>28.32</td>
<td>122-259</td>
</tr>
<tr>
<td>High school</td>
<td>58</td>
<td>190.1</td>
<td>20.47</td>
<td>116-223</td>
</tr>
</tbody>
</table>

\[ F (3) = 6.69, p = .0002 \]

It was hypothesized that the mean CMHI Scale scores for board members with higher levels of education would be greater than mean CMHI Scale scores for board members with lower levels of education. Difference between the mean CMHI Scale scores for the four levels of education was tested at the .05 level of significance with a one-way analysis of variance. The resulting \( F \) ratio of 6.69 with 3 degrees of freedom had a .0002 probability of occurrence.

The Sheffe method of multiple comparisons between means (Glass & Stanley, 1970, p. 388) was used to isolate the group means that
contributed to the rejection of the null hypothesis. Significance was set at the .05 level. The $F$ ratios for the multiple comparison of the means for the four educational levels is presented in Table 9.

Table 9

<table>
<thead>
<tr>
<th>Level</th>
<th>Graduate school</th>
<th>4 years college</th>
<th>Partial college</th>
<th>High school</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate school</td>
<td>---</td>
<td>.46</td>
<td>2.14</td>
<td>3.62*</td>
</tr>
<tr>
<td>4 years college</td>
<td>---</td>
<td>---</td>
<td>1.71</td>
<td>2.69*</td>
</tr>
<tr>
<td>Partial college</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>1.69</td>
</tr>
<tr>
<td>High school</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

*Significant at the .05 level

The resulting $F$ ratios indicated that the mean CMHI Scale scores for board members with graduate school and 4 years college education were significantly higher than the mean CMHI Scale score for board members with high school education. The hypothesis that board members with higher levels of education have a greater level of endorsement of community mental health ideology than board members with lower levels of education was supported by the data.

Social Class Background

Social class background position was estimated for 407 respondents who reported their father's occupation and educational level on
the questionnaires. All five of the social class positions of the Two-Factor Index of Social Class Position (Hollingshead, 1957) were represented in the social class backgrounds of the study sample. The median and modal estimated social class background position was Class IV. The CMHI Scale score data for the social class background positions of board members are presented in Table 10.

<table>
<thead>
<tr>
<th>SCB</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>38</td>
<td>192.6</td>
<td>27.98</td>
<td>185-250</td>
</tr>
<tr>
<td>II</td>
<td>40</td>
<td>205.8</td>
<td>25.57</td>
<td>157-246</td>
</tr>
<tr>
<td>III</td>
<td>100</td>
<td>202.8</td>
<td>23.86</td>
<td>138-259</td>
</tr>
<tr>
<td>IV</td>
<td>164</td>
<td>199.5</td>
<td>26.05</td>
<td>116-257</td>
</tr>
<tr>
<td>V</td>
<td>65</td>
<td>201.6</td>
<td>23.33</td>
<td>141-246</td>
</tr>
</tbody>
</table>

F (4) = 1.69, p = .15

It was hypothesized that the mean CMHI Scale scores for board members with lower social class background positions would be greater than the mean CMHI Scale scores for board members with higher social class background positions. The difference between the mean CMHI Scale scores for the five social class background positions was tested at the .05 level of significance with a one-way analysis of variance. The resulting F ratio of 1.687 with 4 degrees of freedom had a .15 probability of occurrence. The hypothesis that the mean CMHI Scale
scores for board members with lower social class background positions is greater than the mean CMHI Scale scores for board members with higher social class background positions was not supported by the data.

Medical School Education

There were 22 respondents who reported their occupation as M.D., physician, or psychiatrist. It was estimated from the roster of Michigan Community Mental Health Board Members that there were 26 physicians serving on community mental health boards. The study sample of physicians represented 84.6% of the board members with medical school education.

Respondents with medical school education were compared with board members who did not have medical school or nursing school education. The CMHI Scale score data for medical school education are presented in Table 11.

<table>
<thead>
<tr>
<th>Table 11</th>
<th>CMHI Scale Score Data for Medical School Education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Non-medical education</td>
<td>389</td>
</tr>
<tr>
<td>Medical education</td>
<td>22</td>
</tr>
</tbody>
</table>

Since the variance of the two groups was heterogeneous, a random sample of 22 observations was selected from the non-medical school
education respondents for comparative analysis. The random sample had a mean CMHI Scale score of 200.7 with a standard deviation of 26.04 (see Table 12).

Table 12
CMHI Scale Score Data for Random Sample of Non-Medical Education Board Members and Medical Education Board Members

<table>
<thead>
<tr>
<th>Sample</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-medical education</td>
<td>22</td>
<td>200.7</td>
<td>26.04</td>
</tr>
<tr>
<td>Medical education</td>
<td>22</td>
<td>196.5</td>
<td>33.71</td>
</tr>
</tbody>
</table>

$\text{t} (42) = .563, p = .574$

It was hypothesized that the mean CMHI Scale score of board members who had a medical school education would be lower than the mean CMHI Scale score of board members who did not have a medical school education. Difference between the mean CMHI Scale scores for medical school education and non-medical school education groups was tested at the .05 level of significance with a t-test for differences between independent means. The resulting $t$ value of -.5632 had a .574 probability of occurrence. The hypothesis that board members with medical school education have a lower level of endorsement of community mental health ideology than board members without medical school education was not supported by the data.
Nursing Education

There were 19 respondents who reported their occupation as registered nurse on the questionnaires. Respondents with a nursing education were compared with respondents who did not have a nursing or medical school education. The CMHI Scale score data for nursing education are presented in Table 13.

Table 13

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-nursing education</td>
<td>389</td>
<td>199.7</td>
<td>25.32</td>
<td>116-259</td>
</tr>
<tr>
<td>Nursing education</td>
<td>19</td>
<td>205.4</td>
<td>23.94</td>
<td>163-236</td>
</tr>
</tbody>
</table>

\[ t (114) = .96, p = .339 \]

It was hypothesized that the mean CMHI Scale score of board members with a nursing education education would be lower than the mean CMHI Scale score of board members without a nursing education. The difference between the mean CMHI Scale scores for the nursing education and non-nursing education groups was tested at the .05 level of significance with a t-test for differences between independent means. The resulting \( t \) value of .9574 had a .339 probability of occurrence. The hypothesis that the mean CMHI Scale score of board members with a nursing education is lower than the mean CMHI Scale score for board members without a nursing education was not supported by the data.
Years Since Initially State Funded

The number of years since a board was initially state funded was obtained from the public records of the Michigan Department of Mental Health. The range for this variable was 3-14 years with a median of 12 years and a mode of 13 years.

Four categories were developed for the number of years since a board was initially state funded: (a) 3-5 years, (b) 6-8 years, (c) 9-11 years, and (d) 12-14 years. Respondents were assigned to the categories by their specific board membership. Board membership was determined from questionnaire codes for 427 respondents. The CMHI Scale score data for years since initially state funded are presented in Table 14.

<table>
<thead>
<tr>
<th>Years</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5</td>
<td>66</td>
<td>195.8</td>
<td>25.60</td>
<td>116-246</td>
</tr>
<tr>
<td>6-8</td>
<td>98</td>
<td>198.7</td>
<td>23.33</td>
<td>140-257</td>
</tr>
<tr>
<td>9-11</td>
<td>36</td>
<td>192.3</td>
<td>27.25</td>
<td>138-241</td>
</tr>
<tr>
<td>12-14</td>
<td>227</td>
<td>202.7</td>
<td>26.36</td>
<td>122-259</td>
</tr>
</tbody>
</table>

\[ F (3) = 2.61, \ p = .0509 \]

It was hypothesized that there is a difference between the mean CMHI Scale scores for the four categories of years since boards were

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initially state funded. The difference between the mean CMHI Scale scores for the four categories was tested at the .05 level of significance with a one-way analysis of variance. The resulting $F$ ratio of 2.613 had a .0509 probability of occurrence. The hypothesis that there is a difference between the mean CMHI Scale scores for the four categories of years since boards were initially state funded was not supported by the data.

Rural-Urban Complexity

Rural-urban complexity referred to the percentage of the population of a county or counties served by a board that was defined as rural by the U.S. Bureau of Census (1970). Four categories of rural-urban complexity were developed for analysis of this variable: (a) 0%-24% rural, (b) 25%-49% rural, (c) 50%-74% rural, and (d) 75%-100% rural. Respondents were assigned to the categories by their specific board membership. Board membership was determined from questionnaire codes for 427 respondents.

The median and modal rural-urban complexity category was 50%-74% rural. The CMHI Scale score data for rural-urban complexity are presented in Table 15.

It was hypothesized that the mean CMHI Scale scores for board members serving predominately rural populations is higher than the mean CMHI Scale scores for board members serving predominately urban populations. Difference between mean CMHI Scale scores for the four categories of rural-urban complexity was tested at the .05 level of significance with one-way analysis of variance. The resulting $F$ ratio
of 1.594 with 3 degrees of freedom had a .1901 probability of occurrence.

Table 15
CMHI Scale Score Data for Rural-Urban Complexity

<table>
<thead>
<tr>
<th>Percent rural</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-24</td>
<td>57</td>
<td>205.1</td>
<td>28.98</td>
<td>137-259</td>
</tr>
<tr>
<td>25-49</td>
<td>87</td>
<td>202.3</td>
<td>24.38</td>
<td>155-257</td>
</tr>
<tr>
<td>50-74</td>
<td>151</td>
<td>198.6</td>
<td>25.23</td>
<td>122-247</td>
</tr>
<tr>
<td>75-100</td>
<td>133</td>
<td>197.3</td>
<td>25.63</td>
<td>116-257</td>
</tr>
</tbody>
</table>

\( F (3) = 1.59, \ p = .1901 \)

Additional analysis was carried out between board members who served populations that were less than 10% rural and board members who served populations that were 100% rural. The CMHI Scale score data for these highly urban and highly rural boards are presented in Table 16.

Table 16
CMHI Scale Score Data for Highly Urban and Highly Rural Boards

<table>
<thead>
<tr>
<th>Percent rural</th>
<th>N</th>
<th>Mean score</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10</td>
<td>22</td>
<td>204.7</td>
<td>31.92</td>
</tr>
<tr>
<td>100</td>
<td>41</td>
<td>199.7</td>
<td>28.69</td>
</tr>
</tbody>
</table>

\( t (61) = .67, \ p = .505 \)
The difference between the mean CMHI Scale scores for the highly urban and highly rural board was tested at the .05 level of significance with a t-test for differences between independent means. The resulting t value was .6706 with a .505 probability of occurrence. The hypothesis that the mean CMHI Scale scores for board members serving predominately rural populations is higher than the mean CMHI Scale scores for board members serving predominately urban populations was not supported by the data.

Since the CMH boards that served predominately rural populations had a higher proportion of members with a high school education or less, the data were analyzed to determine if differences in levels of education influenced the board members' scores by rural-urban complexity. It was necessary to collapse the categories for this additional analysis because there were no board members with less than college education serving a population that was 0-24% rural. The CMHI Scale score data for board members by rural-urban complexity and level of education are presented in Table 17. A comparative analysis of mean scores revealed there was no significant interaction effect between level of education and rural-urban complexity of the population served ($F (3, 411) = .52, p = .67$).
An unexpected finding of this study was that the mean CMHI Scale score for the female board members was significantly higher than the mean CMHI Scale score for male board members ($F_{1, 428} = 9.63, p = .002$). The CMHI Scale score data for female and male board members are presented in Table 18.

Since differences in levels of education was found to have differentiated board members' CMHI Scale scores, additional analysis of the data was carried out to determine if differences in levels of education had contributed to the difference found for the sex of board members. A comparison of the board members' mean CMHI Scale scores by level of education and sex revealed that the significant difference between the sexes was independent of differences in their
s of education ($F_{3,413} = .59, p = .62$). The CMHI Scale score data for board members by level of education and sex are presented in Table 19.

### Table 18

CMHI Scale Score Data for Female and Male CMH Board Members

<table>
<thead>
<tr>
<th>Sex</th>
<th>N</th>
<th>$\bar{X}$</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>172</td>
<td>204.4</td>
<td>24.2</td>
</tr>
<tr>
<td>Males</td>
<td>258</td>
<td>196.7</td>
<td>26.3</td>
</tr>
</tbody>
</table>

$F(1, 428) = 9.63, p = .002$

### Table 19

CMHI Scale Score Data for Board Members by Sex and Levels of Education

<table>
<thead>
<tr>
<th>Level of education</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>$\bar{X}$</td>
</tr>
<tr>
<td>Graduate school</td>
<td>52</td>
<td>212.5</td>
</tr>
<tr>
<td>4 years college</td>
<td>45</td>
<td>203.5</td>
</tr>
<tr>
<td>Partial college</td>
<td>54</td>
<td>201.6</td>
</tr>
<tr>
<td>High school</td>
<td>21</td>
<td>193.8</td>
</tr>
</tbody>
</table>

$F_{3,413} = .59, p = .62$
Summary

The Community Mental Health Ideology Scale scores and demographic data were analyzed for 430 board members who returned usable questionnaires. The study sample represented 65.5% of the Michigan Community Mental Health Board Members.

Comparison of respondents by time of questionnaire return revealed that board members who responded to the initial mailing of questionnaires scored significantly higher on the CMHI Scale than board members who responded to the second mailing of questionnaires. The difference in the mean CMHI Scale scores for the two return groups was found to be independent of sex, age, years of board service, education, social class background, and rural-urban complexity of the population served.

The respondents' CMHI Scale scores were compared with eight demographic characteristics: age, years of board service, level of education, social class background, medical education, nursing education, years since boards were initially state funded, and rural-urban complexity of the population served. Only level of education was found to significantly differentiate respondents' CMHI Scale scores. Board members with higher levels of education had a greater endorsement of community mental health ideology than board members with lower levels of education. An unexpected finding of the study was that female board members had a significantly higher endorsement of CMH ideology than male board members.
CHAPTER V

DISCUSSION AND SUMMARY

The purpose of this study was to investigate the relationship between selected demographic characteristics and the level of endorsement of community mental health (CMH) ideology by citizens serving on community mental health boards. Eight demographic characteristics were selected from a review of related studies for testing with a CMH board population. These characteristics were: age, length of board service, educational level, social class background, medical school education, nursing school education, years since a board was initially state funded, and rural-urban complexity of the population served. The Baker-Schulberg Community Mental Health Ideology Scale (CMHI Scale) was used to measure individual endorsement of CMH ideology. The study population was citizens serving on county CMH program boards in the state of Michigan. The results indicated that only level of education significantly differentiated the levels of endorsement of CMH ideology among this population.

Discussion in this chapter will address the results of this study in comparison with the results of previous studies, the conclusions of the study, and the implications of the results for mental health services and practitioners.
Discussion of Results

Community mental health was conceptualized in this study as a social movement within the mental health field. The objectives of this social movement were to shift the care of the mentally ill from mental institutions to the community and to establish the public health model of prevention as an approach to mental illness in this country. Support for the objectives of the CMH movement is indicated by the extent to which individuals endorse its ideology. Baker and Schulberg (1967) formulated a scale which measured endorsement of five conceptual components of CMH ideology: Population Focus, Primary Prevention, Social Treatment Goals, Comprehensive Continuity of Care, and Total Community Involvement. A series of previous studies have used the CMHI Scale to investigate the endorsement of CMH ideology by populations associated with the mental health field. The results of the present study were compared with the results of these previous studies to determine differences and commonalities in CMH endorsement between the Michigan CMH board population and previously studied populations. The objective of this comparison was to identify possible trends in the acceptance of CMH ideology.

Level of Board Member Endorsement of CMH Ideology

Considering the possible CMHI Scale score range is 38 to 266 the board members' mean score of 199.8 would seem to indicate a strong acceptance of CMH ideology by this sample of Michigan mental health board members. However, in comparison with the scores of previously

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studied populations the Michigan board members had a relatively low endorsement of CMH ideology. The Massachusetts board members of the Baker and Schulberg (1969) study were reported to have a mean CMHI Scale score of 219.1, and the national sample of CMH workers of the Wagenfeld et al. (1974) study were reported to have a mean CMHI Scale score of 208.4. Differences in the demographic characteristics of the three populations does not adequately explain why the Michigan board members scored lower in ideological endorsement than both these previously studied populations. Differences in geographical location and board organization characteristics could have contributed to the differences between the two board member populations. The professional socialization of the CMH workers could partially explain the difference between the CMH workers and the board members. However, one would expect that the influence of professional socialization would have been in the same direction for the two board member populations. Since the Massachusetts board members scored higher than the CMH workers and the Michigan board members scored lower than the CMH workers consideration of other factors is required to explain the Michigan board members' relative low scores.

One possible explanation is that there has been a change in attitudes toward the CMH concepts that are represented by the items of the CMHI Scale. It has been over a decade since Baker and Schulberg (1967) developed the CMHI Scale. During this time CMH programs have expanded to the extent that there is now a national network of CMH centers in operation, and CMH programs have become an established component of the mental health treatment system of many states.
Killian (1964) noted that when a social movement becomes an accepted and enduring part of the social structure its proposed programs for change are made more socially realistic, and its ideology is modified by the larger society to correspond with the programs that are instituted. Thus, the relative low endorsement of CMH ideology by the Michigan board members could be indicative of modifications of the concepts associated with the CMH approach over the past decade.

A CMH concept which appears to have been modified during the past decade is primary prevention. Leading CMH theorists of the 1960's (Bellak, 1964; Caplan, 1964; Dumont, 1968) advocated a social action approach to the primary prevention of mental illness. Proposed programs of primary prevention (Caplan, 1964) involved actions by the mental health practitioners to alter the political and social policies of a community. The aim of this social action approach was to improve the plights of the poor and ethnic minority residents of the community (Wagenfeld, 1972). In contrast to this emphasis on changing present social and political structures the President's Commission on Mental Health (1978) advocated that programs for primary prevention should be "based on principles generally accepted by society" (p. 54). The Commission's recommended prevention strategies focused on the development of programs that would foster the healthy development of children and promote empirical investigation of effective prevention approaches. Thus, the Commission retained prevention of mental illness as a CMH objective, but the means they proposed for achieving this objective are considerably different from the social action approach proposed by the earlier CMH theorists.
Other recent publications also indicate that beliefs regarding the concept of prevention of mental illness have changed over the past decade. Bloom (1979) noted that a new paradigm for primary prevention of mental illness has arisen within the CMH field. The new paradigm focuses on identification and intervention with individuals who are experiencing stressful life events. Based on the assumption that everyone is potentially vulnerable to stressful events in life the new paradigm represents a shift from focusing on predisposing factors, such as sociological influences, to altering the negative outcomes of precipitating factors. Bloom (1979) attributed the shift in prevention paradigms in part to the lack of success of the previous social action approach and its unrealistic demand on available resources. Ciarlo and Diamond (1979) also questioned the practicality of the sociopolitical approach to prevention and identified the concept of prevention as the major, unresolved issue in community mental health.

Since items of the CMHI Scale related to prevention represent the social action approach it is possible that this scale is no longer validly measuring the present orientation to this CMH concept. The Michigan board members' relative low CMHI Scale scores could have been related to changes which have occurred in the beliefs regarding the appropriate CMH approach to prevention of mental illness. Unsolicited comments by the respondents on the questionnaires suggested that this was indeed the case. The following are examples of respondents' comments.

"As it is now, prevention is not realistic."
"It is not yet known if prevention is a useful approach."

"Social change is not practical."

"Prevention and social change are no longer easy for me to define. Who decides what is appropriate behavior and what is in need of prevention."

Another area of change in community mental health over the past decade which could have contributed to the Michigan board members' relative low CMHI Scale score is the availability of mental health personnel. The President's Commission on Mental Health (1978) noted that there has been a marked increase in recent years in the number of professional mental health practitioners, and the major mental health personnel problem is not one of inadequate numbers but one of maldistribution of personnel (p. 36). Rural areas and poor urban communities have proportionally fewer mental health practitioners. In addition to the maldistribution of personnel the Commission (1978) also noted there has been a reduction in the numbers of medical school graduates entering psychiatric residency programs which is creating a shortage of psychiatrists for CMH services (p. 36-37).

Items of the CMHI Scale reflect the mental health manpower conditions of the 1960's, which was a general shortage of professionally trained mental health practitioners. The increased availability of such mental health professionals as psychologists, social workers, and psychiatric nurses and the decreased availability of psychiatrists could have influenced the board members' responses to CMHI Scale items that reflected the previous manpower conditions of a decade ago. There was some indication that the items which referred to "limited
professional resources" and "professional manpower shortage" (see Community Mental Health Board Member Survey, Appendix A) were confusing to the respondents as they occasionally circled these phrases or placed question marks above them. Two respondents wrote comments beside these items indicating that their boards had not experienced any lack of availability of mental health personnel. The item which stated it was the psychiatrist's job to locate the mentally disordered in a community was negatively endorsed by the majority of the respondents. A few respondents placed question marks above this item and one respondent commented, "It was not the psychiatrist's job." It is possible that since these items did not reflect the current mental health manpower conditions they did not validly measure the respondents' attitudes toward the CMH concepts the items represented.

An item analysis of the board members' CMHI Scale responses was not considered appropriate for the purpose of this study as the CMHI Scale was reported to be unifactorial by design (Baker & Schulberg, 1967). Thus, differences in the board members' support for the particular concepts represented by the scale could not be statistically examined meaningfully.

In summary, the level of endorsement of CMH ideology by the board members of the present study was lower than previously studied populations. This lower endorsement level appears to be related to recent changes in the CMH field. Two changes which could have influenced the board members' responses are beliefs concerning the appropriate approach to prevention of mental illness and the increased availability of non-psychiatrist mental health professionals for CMH.
services.

Age of Board Members

The finding of this study that age did not differentiate board members' level of endorsement of CMH ideology was consistent with the findings for this variable for CMH workers by Langston (1970) and Robin and Wagenfeld (1976). It was assumed in this study that younger board members who received their formal education during the 1960's, when there was increased concern regarding the need for social change, would have a greater endorsement of CMH ideology than older board members who had received their formal education in earlier decades. It appears that neither the younger board members or the younger CMH workers were sufficiently influenced by the social climate of the 1960's to endorse CMH ideology differently from their older counterparts.

Length of Board Service

The finding that length of board service did not differentiate board members' level of endorsement of CMH ideology was consistent with the results for this variable in previous studies. Length of time employed in CMH centers was not found to be related to endorsement of CMH ideology by the paraprofessional mental health workers in the Poovathumkal (1973) study or the professional mental health workers in the Robin and Wagenfeld (1976) study. Since the nature of individual involvement with CMH boards is considerably different from employment in CMH centers length of time involved with CMH programs
was retested as an influencing factor of board members' endorsement of CMH ideology. It appears that experience with CMH programs, whether in a board member role or a service delivery role, does not influence an individual's beliefs about community mental health as a treatment orientation. This finding would seem to indicate that even though CMH programs are a realization of the CMH movement they evidently are not conveying and promoting the ideology of the movement.

**Level of Education**

Level of education did discriminate the board members' level of endorsement of CMH ideology. Board members with graduate school and 4 years college education endorsed CMH ideology at a significantly higher level than board members with a high school education.¹ A possible explanation for this finding is that advanced education may expose individuals to social theories of human behavior which are consistent with the theoretical basis of the CMH treatment orientation.

Previous studies which investigated the relationship between education and endorsement of CMH ideology by CMH workers populations reported mixed results. Langston (1970) found a positive correlation between years of education and CMH endorsement by the staff of two CMH centers, except for the medically education staff members. Among a national sample of CMH workers Robin and Wagenfeld (1976) found that

¹The influence of less than a high school education was not analyzed in this study because of the small number of board members in these educational categories.
higher levels of education were related to greater ideological endorse-ment by only the social workers and nurses. Differences in the findings of these previous studies and the present study could be attributed to differences in the populations studied. The board members were occupationally and educationally a more heterogeneous population than the CMH workers. CMH workers are likely to have received professional training beyond high school as a requirement for CMH center employment, and workers in the same profession were likely to have had similar educational experiences. The results of the present study indicated that level of education only differentiated the ideological endorsement between board members with higher education and members with high school education. Thus, level of education appears to be a rough predictor of endorsement of CMH ideology among educationally heterogeneous population. Among populations of individuals with higher levels of education other socialization factors appear to be more potent variables of their endorsement of CMH ideology.

Social Class Background

The social class background of board members did not significantly differentiate their levels of endorsement of CMH ideology. This finding was inconsistent with the results reported by the previous study which investigated social class background as a factor of commitment to CMH ideology. Del Gaudio et al. (1975) reported that among psychotherapists in an outpatient clinic the therapists from Socioeconomic Status (SES) I scored significantly lower on the CMHI Scale than the therapists from SES II through SES V. Although

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the board members of the present study from SES I also ranked lower in their ideological endorsement than the board members from SES II through SES V; this difference was not statistically significant. The failure of this difference to reach significant proportions could have been related to differences in the characteristics of the two study populations. The board members represented a more heterogeneous population than the psychotherapists in their educational experience and occupations. It is possible that social class background does exert some influence on board members' attitudes toward CMH ideology. However, this influence appears to have been diluted by other factors in this demographically heterogeneous population.

Medical and Nursing School Education

Neither medical school or nursing school education differentiated the board members' level of endorsement of CMH ideology. The predictions for these variables were based on the findings by previous studies (Del Gaudio et al., 1975; Langston, 1970; Robin & Wagenfeld, 1976) that among mental health professional affiliations physicians and nurses consistently ranked lowest in their commitment to CMH ideology. The finding that physicians and nurses were not different from other board members in their endorsement of CMH ideology was probably due to the relative low endorsement level of the total sample of board members.

A comparison of the physician and nurse board members' mean CMHI Scale scores with the mean CMHI Scale scores for physicians and nurses in previous studies (Del Gaudio et al., 1975; Langston, 1970; Robin &
Wagenfeld, 1976) revealed a consistency in these professional groups' level of endorsement of CMH ideology. It appears that even when serving in a citizen board member role physicians and nurses endorse CMH ideology at a level that is remarkably similar to that of their colleagues who are employed in CMH programs. This finding provides additional support for professional socialization as a contributing factor to attitudes toward CMH concepts and indicates that the CMHI Scale has retained its reliability in assessing individuals' commitment to CMH ideology.

**Years Since a Board Was Initially State Funded**

The hypothesis that there was a relationship between years since CMH boards were initially funded by the state and their level of endorsement of CMH ideology was not supported by the data of this study. The basis for this hypothesis was the proposal by Schulberg and Baker (1975) that in order for an ideology to sustain support members of the movement must perceive that the goals embodied in the ideology were being met to some degree. It was assumed that the CMH boards that had been in existence longer would have had more opportunity to establish programs and political influence that could test the success of their ideological orientation.

The difference in the board members' mean CMHI Scale scores by years since initially state funded was significant at the .06 level of probability. However, the lack of a consistent direction in the rank order of the mean scores indicated that this difference was most likely a spurious finding. An examination of the data did not reveal
any consistent geographical pattern in the initial funding of CMH boards that could have provided an alternative explanation for the results obtained.

In retrospect, a more accurate assessment of a board's opportunity to test the success of their CMH orientation would have been a measurement of the number and variety of services provided by their CMH program. Also, the board members' ratings of the success of their CMH program could possibly have provided meaningful information about the relationship between perceived goal achievement and endorsement of CMH ideology.

**Rural-Urban Complexity of the Population Served**

The hypothesis that board members who served predominately rural populations have a greater endorsement of CMH ideology than board members serving predominately urban populations was not supported by the data of this study. The rank order of the mean CMHI Scale scores for the four categories of rural-urban complexity indicated a trend in the opposite direction of what was predicted. Additional analysis of the data revealed there was no significant interaction effect between level of education and rural-urban complexity of the population served. The rank order of the mean scores in this analysis indicated that even when level of education was controlled rural board members had a tendency to endorse CMH ideology at a lower level than urban board members.

The prediction for rural-urban complexity was based on the findings of a previous study by Wagenfeld et al. (1974) which revealed
that workers employed in rural CMH centers had a greater endorsement of CMH ideology than workers employed in urban CMH centers. The inconsistency in the results for CMH workers and CMH board members could have been due to differences in the characteristics of the two populations. Wagenfeld et al. (1974) suggested that rural CMH centers may attract workers that are more committed to the ideology of community mental health. Citizens serving on CMH boards are likely to have chosen their rural residency for other reasons. If the rural CMH centers are attracting workers that are highly committed to CMH ideology then an implication of the findings of the present study would be a potential for conflict to occur between rural CMH workers and their board members.

**Sex of Board Members**

An unexpected finding of this study was that female board members had a higher endorsement of CMH ideology than male board members. Additional analysis of the data revealed that the significant difference between the sexes was independent of any differences in their levels of education. Since no previous studies have reported sex as a factor related to CMH endorsement it is possible that the result for sex differences in the present study represented a spurious finding. Another possibility is that the higher ideological endorsement by female board members represented a true finding and could be related to the recent social movement to promote equal opportunities for women. Involvement with the women's movement could sensitize females to the effects of social inequities and the use of social
action to redress these inequities. The use of social action as an approach to social problems would concur with the CMH approach to mental illness represented by the CMHI Scale. Perhaps women who endorse the ideology of the women's movement are more actively involved in community affairs and thus volunteer to serve on community mental health boards.

Conclusions

A comparison of the findings of this study with those of previous studies of CMH ideology led to the following conclusions regarding trends in individual acceptance of CMH ideology.

1. The finding that the board members of the present study ranked lower in their endorsement of CMH ideology than previously tested populations appeared to be related to recent changes in the CMH field. Changes in beliefs regarding the appropriate approach to primary prevention and changes in the mental health manpower conditions in the country appeared to have influenced board members' responses to the items of the Baker-Schulberg Community Mental Health Ideology Scale. Since the items of this scale do not reflect the changes in community mental health which have occurred over the past decade it is quite possible that it is no longer a valid measurement of individual endorsement of CMH ideology.

2. The demographic characteristics which differentiated the acceptance of CMH ideology among CMH worker populations did not differentiate the acceptance of CMH ideology among mental health board members of this study. These demographic characteristics were age,
social class background, medical school education, nursing school education, and rural-urban complexity of the population served. It appears that among populations which are more heterogeneous than CMH workers in their occupations and educational experiences these demographic variables lose their potency as predictors of CMH endorsement. The results of this study suggest that there is probably a multiplicity of variables that interact to influence an individual's beliefs regarding mental health treatment. Without a commonly shared socialization experience, such as professional mental health education, the primary influences on mental health beliefs apparently exist in the personal characteristics and experiences of individuals.

3. The finding that years of board service was not related to board members' endorsement of CMH ideology was consistent with the results for years of CMH center employment for mental health workers. It appears that commitment to the CMH approach is acquired prior to experience with CMH programs and additional experience does not strengthen or diminish this initial commitment level. Although CMH programs were considered to be the realization of the objectives of the CMH movement they evidently are not serving as purveyors of the ideology.

4. The finding that board members with high school education were less supportive of CMH ideology than board members with higher levels of education indicates that educational experiences are an influencing factor in individual endorsement of CMH ideology.
Implications for the Mental Health Field

The conclusions of this study suggested the following implications for community mental health programs and professional mental health education.

Implications for CMH Programs

The possible changes in CMH beliefs regarding primary prevention that were reflected in the board members' responses have implications for the future direction of CMH programs. The prevention strategies recommended by the President's Commission on Mental Health (1978) and the new prevention paradigm which was described by Bloom (1979) indicate that the focus of primary prevention efforts has shifted to promoting the coping abilities of individuals to enable them to deal more effectively with stressful life events. The Commission (1978) advocated that children should be the Nation's first priority for receiving prevention services, which included prenatal and early infant care as well as child care programs that promote healthy physical and emotional development. These prevention services are beyond the scope of the present resources of most CMH programs, and commitment to the new focus of prevention would require CMH program boards to develop cooperative and interdisciplinary programs with health care and educational agencies in a community. Movement toward more comprehensive care programs suggests that the boundaries between mental health care and physical health care will be less distinct. Thus, CMH program boards will need to increasingly view mental health services as an
integral part of a community's human service programs. The combining of services would also require changes in administrative policies related to sharing of fiscal responsibilities and personnel.

The finding that CMH programs are not serving as effective socializers to the ideology has implications for the need to develop promotional activities external to the programs. The finding that education is an influencing factor in individual endorsement of CMH ideology implies that these promotional activities need to be in the form of community education programs. The need for community education programs is additionally supported by the finding that board members with a high school education were less supportive of CMH ideology than board members with higher levels of education. It could be expected that the majority of citizens in a community would have less than a college education and may not have had the opportunity to be exposed to the social theories of human behavior which form the basis of the CMH approach to mental illness. The relatively low endorsement by the high school educated board members could be a reflection of a similar attitude by a large proportion of a community. As the care of the mentally ill increasingly shifts from state hospitals to community based facilities CMH programs will require the cooperation of community residents to locate and support the development of these facilities in their neighborhoods. The findings of this study would indicate that CMH programs will need to more actively engage in community education to promote citizen understanding and acceptance of CMH beliefs if they are to successfully achieve their program objectives.
Implications for Professional Education

The changes in the CMH field which were reflected in the board members' responses have implications for the professional education of mental health practitioners. The new paradigm for primary prevention will require the employment of mental health practitioners who are prepared to function in a variety of service settings that will include health care and educational settings in the community. Educational programs for mental health professionals and health care professionals need to increasingly consider interdisciplinary educational experiences to prepare their graduates to function more effectively together in comprehensive human service programs.

The increased focus on comprehensive mental health care of children will require employment of greater numbers of mental health specialists in the areas of child development, special education, and treatment of childhood mental disorders. There is presently a lack of available practitioners who have been prepared to meet the mental health needs of children. Child specialist programs are currently needed that will prepare practitioners not only to diagnose and treat childhood mental disorders, but also to prepare them to effectively engage in teaching, consultation, and supervision in an interdisciplinary setting.

The board members' responses also reflected a change over the past decade in mental health manpower conditions. The President's Commission (1978) noted that although there is an adequate supply of mental health practitioners the maldistribution of this supply of
personnel is the major mental health personnel problem facing the country. Rural areas and poor urban communities continue to be underserved because of the lack of prepared personnel to staff their CMH programs. A contributing factor to the inability of CMH programs to recruit and retain personnel for underserved areas is the professional lack of preparation to meet the special mental health care needs of rural, urban poor, and minority populations. The needs, values, and special problems confronting the underserved populations are not well represented in the curricula of present professional training programs (President's Commission on Mental Health, 1978, p. 36). In order to prepare and encourage practitioners to work in underserved areas professional education programs will need to develop special curricula that not only provide increased theory of the particular needs of underserved populations, but also provide supervised educational experiences in working with these populations.

The finding that professional socialization is a significant factor in individual endorsement of CMH ideology makes professional education a highly relevant area for the promotion and understanding of CMH concepts. The President's Commission (1978) reported that there has been a decrease in the number of medical school graduates entering psychiatric residency programs. This trend is perhaps related to the consistently low endorsement of CMH ideology by physicians as a professional group. Medical schools appear to be not socializing their students to CMH beliefs. Perhaps if there were increased incorporation of CMH concepts in medical school education and medical students were provided more educational experiences in CMH...
treatment settings graduates would elect mental health as a specialty area with increased frequency, and physicians would be more supportive of CMH beliefs.

Recommendations for Further Research

The results of this study suggested the following recommendations for further investigation of community mental health ideology.

Reassessment of Community Mental Health Concepts

Killian (1964) proposed that throughout the course of a social movement there is continuous revision of the values and norms which constitute the movement's ideology. The results of this study suggest that this indeed has been the case for community mental health. Thus, there is a need for further research to reassess the concepts which compose the ideology of community mental health. Knowledge about the CMH concepts which are currently being advocated in the field is needed to provide information about the direction community mental health is taking relative to other mental health treatment orientations and to identify the major issues that are sources of conflict within the field.

Over a decade ago Baker and Schulberg (1967) identified the concepts of CMH ideology as (a) professionals assuming responsibility for an entire population rather than an individual patient only, (b) primary prevention of mental illness through amelioration of harmful environmental conditions, (c) treating patients with the goal of social rehabilitation rather than personality reorganization,
(d) continuity of care for the mentally ill, and (e) the use of non-professionals as well as professionals in mental health treatment. An examination of the board members responses to the items of the CMHI Scale indicated that these ideological concepts were not uniformly endorsed as approaches to community mental health. There appeared to be more uniform endorsement of items representing continuity of care and the use of nonprofessionals for mental health treatment. Considerable variability of endorsement appeared to occur with items representing the concepts of a population focus, primary prevention, and social rehabilitation. This pattern of responses suggests that the concepts which extend the availability and use of clinical treatment are widely accepted, but there is less agreement about the acceptance of the concepts which apply a public health orientation to mental illness.

The adoption of a public health orientation to mental illness made community mental health notably different from previous mental health treatment orientations. The major difference was an ideological shift from focusing on mental illness to focusing on mental health. Similar to the public health model of promoting physical well being the CMH approach advocated promoting the mental well being of a population by reducing harmful social influences, increasing individuals' coping skills, and strengthening interpersonal and economic support systems (Hume, 1966).

It is perhaps the public health orientation of the CMH approach which has been the most difficult aspect of the ideology to translate into action within the realities of CMH practice. Thus, CMH concepts
which reflect the public health orientation may have undergone the most modification in the process of actualizing the ideology over the past decade. The adoption of this orientation was the most novel aspect of community mental health which set it apart from earlier clinical models of mental health treatment. If the public health view of mental health treatment has been abandoned in the current ideology then community mental health has only extended the clinical treatment model in the community and it has not become the "bold new approach" that was originally envisioned at its inception. Further research assessing the current CMH ideology could provide information about the extent to which the public health orientation has been retained as an advocated approach to mental illness.

Effect of Educational Programs for Board Members

The finding that education was a variable of board members' endorsement of CMH ideology suggests there is a need to investigate the area of educational programs for board members. It is possible that the board members with college and graduate school experience were predisposed to their endorsement of community mental health because of their previous exposure to social theories of human behavior. Thus, educational programs which promote board members' understanding of the theoretical basis of community mental health could foster their support of the objectives and values of this approach to mental health treatment.

Research endeavors in this area would need to assess the educational needs of board members, develop relevant and practical programs...
to meet these needs, and evaluate the programs' effectiveness in promoting commitment to CMH ideology. Educational methods which can be determined to be effective for increasing board members' understanding and support of community mental health could also provide needed information for the development of similar educational programs for the community.

Summary

This study investigated the relationship between selected demographic characteristics and the level of endorsement of community mental health ideology by community mental health board members. Eight demographic characteristics were selected from a review of related studies for testing with a community mental health board population. These characteristics were: age, years of board service, level of education, social class background, medical school education, nursing school education, years since a board was initially state funded, and rural-urban complexity of the population served. The Baker-Schulberg Community Mental Health Ideology Scale was used to measure individual endorsement of community mental health ideology. The study population was citizens serving on county community mental health program boards in the state of Michigan.

Data were collected by a mail questionnaire which contained the 38 items of the Community Mental Health Ideology Scale and questions eliciting demographic characteristics of subjects. A total of 430 usable questionnaires were returned. This sample represented 65% of the board population.
Analysis of the data revealed that among the eight demographic characteristics studied only level of education differentiated the board members' endorsement of community mental health ideology. Board members with a college and graduate school education had a higher ideological endorsement than board members with a high school education. An unexpected finding of this study was that female board members had a higher endorsement of the ideology than male board members.

A comparative analysis of the results of this study with those of previous studies of community mental health ideology revealed that the present sample of board members had a lower endorsement of the ideology than previously studied samples of board members and community mental health workers. A possible explanation offered for this finding was that the ideological concepts measured by the Baker-Schulberg Scale have changed over the past decade.

Implications of the findings for community mental health were proposed. Suggestions for further research were assessment of possible changes in community mental health ideology and study of the effects of educational programs on endorsement of the community mental health ideology.
APPENDICES
COMMUNITY MENTAL HEALTH BOARD MEMBER SURVEY

1. Age
   - Under 25
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - 65 and over

2. Length of service on mental health board
   - Less than 1 year
   - 1-3 years
   - 4-6 years
   - 7-9 years
   - 10 or more years

3. Sex
   - Female
   - Male

4. Your present occupation (please be as specific as possible)

5. What were or are your parents' occupations (please be as specific as possible).
   Father _________________________
   Mother _________________________

6. Level of formal education you have completed.
   - Graduate school
   - 4 years college
   - 1-3 years college or vocational program
   - High school
   - 1-3 years high school
   - Junior high school
   - Less than 7 years of school

7. Level of formal education completed by father.
   - Graduate school
   - 4 years college
   - 1-3 years college or vocational program
   - High school
   - 1-3 years high school
   - Junior high school
   - Less than 7 years of school

8. Level of formal education completed by mother.
   - Graduate school
   - 4 years college
   - 1-3 years college or vocational program
   - High school
   - 1-3 years high school
   - Junior high school
   - Less than 7 years of school

The following is a series of statements about community mental health and different aspects or ways of viewing life. Please read each of the statements carefully in the order in which it appears. Indicate the extent to which you personally agree or disagree with each statement by circling one of the six symbols given which best represents your own thinking about the statement.

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

(over please)
9. Every mental health center should have formally associated with it a local
citizen's board assigned significant responsibilities.

10. Our time-tested pattern of diagnosing and treating individual patients is
still the optimal way for us to function professionally.

11. 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.

12. Our responsibility for patients extends beyond the contact we have with them
in the mental health center.

13. 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.

14. Such public health programs as primary prevention services are still of little
value to the mental health field.

15. A mental health program should direct particular attention to groups of people
who are potentially vulnerable to upsetting pressures.

16. The planning and operation of mental health programs are professional functions
which should not be influenced by citizen pressure.

17. Mental health programs should give a high priority to lowering the rates of new
cases in a community by reducing harmful environmental conditions.

18. The mental health specialists should seek to extend their effectiveness by
working through other people.

19. Mental health professionals can only be responsible for the mentally ill who
come to them; they cannot be responsible for those who do not seek them out.

20. Our program emphasis should be shifted from the clinical model, directed at
specific patients, to the public health model, focusing upon populations.

21. Understanding of the community in which they work should be made a central
focus in the training of mental health professionals.
22. The control of mental illness is a goal that can only be attained through psychiatric treatment.  

23. Mental health professionals assume responsibility not only for their current case-load but also for unidentified potentially maladjusted people in the community.  

24. Our current emphasis upon the problems of individual patients is a relatively ineffective approach for easing a community's total psychiatric problem.  

25. Our professional mandate is to treat individual patients and not the harmful influences in society.  

26. Our efforts to involve citizens in mental health programs have not produced sufficient payoff to make it worth our while.  

27. The locus of mental illness must be viewed as extending beyond the individual, and into the family, the community, and the society.  

28. Mental health professionals can be concerned for their patient's welfare only when having them in active treatment.  

29. Mental health consultation is a necessary service which we must provide to community caregivers who can help in the care of the mentally ill.  

30. 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.  

31. Psychiatrists can only provide useful services to those people with whom they have direct personal contact.  

32. Skill in collaborating with non-mental health professionals is relatively unimportant to the success of our work with the mentally ill.  

33. The mental health center is only one part of a comprehensive community mental health program.  

34. Mental health professionals should only provide their services to individuals whom society defines as mentally ill or who voluntarily seek these services.  

35. We should deal with people who are not yet sick by helping them to develop ways for coping with expected life difficulties.
36. We should not legitimately be concerned with modifying aspects of the patient's environment but rather in bolstering his/her ability to cope with it.

37. It is poor treatment policy to allow non-psychiatrists to perform traditional psychiatric functions.

38. 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.

39. The hospital and community should strive for the goal of each participating in the affairs and activities of the other.

40. Social action is required to insure the success of mental health programs.

41. In view of the professional manpower shortage, existing resources should be used for treatment programs rather than prevention programs.

42. Each mental health center should join the health and welfare council of each community it serves.

43. The responsible mental health professional should become an agent for social change.

44. We can make more effective use of our skills by intensively treating a limited number of patients instead of working indirectly with many patients.

45. By and large, the practice of good psychiatry does not require very much knowledge about sociology and anthropology.

46. Community agencies working with the patient should not be involved with the different phases of a patient's hospitalization.

THANK YOU FOR YOUR COOPERATION

I wish to receive a summary of the research report. Yes____ No____
Appendix B

Correspondence
March 22, 1979

I am writing to request your assistance with my doctoral dissertation research at Western Michigan University. The study I am undertaking concerns a survey of opinions of members of community mental health boards in Michigan. I am using a mail questionnaire for data collection and need the names and addresses of all members presently serving on your mental health board. It would be appreciated if you would send me this list of current members and their addresses as soon as possible.

Thank you for your anticipated cooperation.

Sincerely,

Kathryn Thiel
Doctoral Candidate
April 26, 1979

I am writing to request your cooperation and participation in my doctoral dissertation research at Western Michigan University. The study I am undertaking concerns a survey of opinions of members of community mental health boards in Michigan. The study has been endorsed by my graduate faculty.

Specifically, the study will identify opinions held by board members about a number of mental health concepts and personal views on life issues. Research utilizing a similar questionnaire has been conducted with mental health workers. This study will provide for the first time a measure of the endorsement of community mental health concepts by mental health board members. All of the 55 Michigan Community Mental Health Service Boards are included in the study.

Participation in this study will require not more than 15 minutes of your time to complete the enclosed questionnaire and to return it in the stamped, return envelope. As you understand, research such as this requires a very high level of return of questionnaires, if the results are to be meaningful. I therefore ask your cooperation.

You may notice that your questionnaire has a number in the upper right hand corner. This number will inform me that you have returned your questionnaire. Your number will then be removed. All responses to the questionnaire will remain confidential and will not be reported in any way so as to link data with a particular individual or community.

A summary of the results of the survey will be made available to you when the study is completed. Please indicate on your questionnaire if you wish to receive this report. Thank you for your anticipated cooperation.

Sincerely,

Kathryn Thiel  
Doctoral Candidate

Robert Hopkins Ed.D.  
Professor, Dept. Counseling and Personnel
June 5, 1979

On April 26, 1979 I mailed letters to all Michigan Community Mental Health Board Members requesting their participation in my doctoral dissertation research at Western Michigan University. This study concerns a survey of opinions held by board members about a number of mental health issues. It will provide for the first time a measure of the endorsement of community mental health concepts by mental health board members.

Although one-half of the Michigan board members have responded to the survey this response is insufficient to produce unbiased results for a survey of this nature. Your participation is needed if the results are to be meaningful. I therefore respectfully request your cooperation.

Participation in this study will require not more than 15 minutes of your time to complete the enclosed questionnaire and return it in the stamped, return envelope. All responses to the questionnaire will remain confidential and will not be reported in any way so as to link data with a particular individual or community.

A summary of the results will be made available to you if you indicate on your questionnaire that you wish to receive this report. Thank you for your anticipated cooperation in helping to make the outcome of this survey as accurate as possible.

Sincerely,

Kathryn Thiel
Doctoral Candidate

Robert Hopkins Ed.D.
Professor, Dept. Counseling and Personnel
BIBLIOGRAPHY


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