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CITIZEN PARTICIPATION IN COMMUNITY MENTAL HEALTH: MASSACHUSETTS AREA BOARD MEMBERS' EVALUATION CRITERIA FOR PARTICIPATION

by
Douglas King Decker

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Political Science)
in The University of Michigan
1974

Doctoral Committee:

Professor M. Kent Jennings, Chairman
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CHAPTER ONE

INTRODUCTION

Although recent innovations in American citizen participation practice are important to an overall understanding of our political system, there is little agreement on the criteria by which they can be evaluated.[1] The bias introduced by the various perceptions of purpose held by different observers makes the conclusions as to usefulness and potential success vary substantially. Progress in building a systematic theory of citizen participation depends upon being able to reduce the confusion about criteria and settle on measures for evaluation.

It is not the purpose of this dissertation to eliminate the barriers to construction of a general theory of citizen participation. Such would not be possible at this time even if it were intended. But it is our purpose to contribute a significant piece of information to the topic area: it is our purpose to fill in a noticeable gap in the literature on the criteria for the evaluation of recently introduced forms of citizen participation.

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[1]Hans B. C. Spiegel and Stephen C. Mittenthal, "The Many Faces of Citizen Participation: A Bibliographic Overview," Citizen Participation in Urban Development: Concepts and Issues, ed. Hans B. C. Spiegel (NTL Institute for Applied Behavioral Science, 1968), p. 3

Before we get directly into a presentation of the topic of this dissertation we must set the stage both with a review of the relevant parts of the modern history of citizen participation and with the construction of a systematization of existing approaches to its evaluation. We will begin with the modern history.

The Modern History of Citizen Participation

Citizen participation in government is an old American tradition which has been greatly expanded in the past twenty or twenty-five years. Where once the term might have evoked images of regular elections, town meetings, or even interest group activities, it now suggests that such activities as the civil rights movement, Saul Alinsky's Peoples' Organizations, the councils of urban renewal and redevelopment, and the Area Boards of community mental health.[1]

The recent proliferation of citizen participation has been attributed to many causes, most of them a concomitant of what Toffler calls rapid social change.[2] The process of urbanization with all it entails is often singled out as a special factor.[3] But a special cause, secondary to the broader process of change, can be identified specifically for one set of innovations--those which have grown up

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[1] Ibid., p. 13.

[2] Alvin Toffler, Future Shock (New York: Random House, 1970).

[3] Jewel Bellush and Murray Hausknecht, "Urban Renewal: An Historical Overview," Urban Renewal: People, Politics, and Planning, ed. Jewel Bellush and Murray Hausknecht (New York: Anchor Books, Doubleday and Co., Inc., 1967), pp. 3-16.

as citizen boards and councils for governmental service agencies or projects. This cause is governmental support and encouragement.[1]

In the review that follows we will concentrate on that part of the modern history which resulted in governmental sponsorship of innovations in citizen participation. We exclude other innovative forms not because they are unimportant, but because we will be more concerned with the quasi-governmental forms in the remainder of this dissertation.

The history of quasi-governmental citizen participation in the recent period is usually dated from the passage of the federal Housing Act of 1954. It was in this act that the federal government first specified that a program of citizen participation would be a prerequisite for a "workable program" of urban renewal.[2] Citizen participation was seen as a necessary element because previous efforts without it had been "greeted with considerable opposition," and it was thought that some of the controversy could be eliminated by careful involvement of relevant citizen groups.[3] It was determined that citizen participation should be a "keystone" of a "workable program and the means by which citizens inform themselves on their community's activities, assist in developing renewal objectives

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[1]These governmentally encouraged boards and councils are not really new in form for there have been many precursors, e.g., "Overseer" Boards in Welfare in the 1930's, Selective Service Boards in the 1940's, etc. But they are new by their proliferation.

[2]Ibid., p. 15.

[3]James Q. Wilson, "Planning and Politics: Citizen Participation in Urban Renewal," ed. Spiegel and Mittenthal, op. cit., p. 46.

and goals, inventory community resources, learn and pursue methods for achieving goals, and serve to bring private resources into the effort."[1]

In 1966, the principle of citizen participation was augmented by the Demonstration Cities and Metropolitan Development Act. This new piece of legislation required that a "model cities program" provide for "widespread citizen participation in the program."[2] It made explicit that citizens should be involved in planning and implementation of the program as a means "of introducing the views of area residents in policy-making."[3] The reasoning behind this increased role was a "growing conviction that improving the quality of life of the residents of the model neighborhood can be accomplished only by the affirmative action of the people themselves."[4]

In the formulae for citizen participation and the justifications associated with the two federal acts above, we see an evolving understanding of citizen participation in governmental programs. At first the purpose was merely to protect against allegations of bureaucratic authoritarianism; later it became an integral part of a social program.

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[1] Spiegel and Mittenthal, eds., op. cit., "Citizen Participation Under the Workable Program for Community Improvement," Department of Housing and Urban Development, pp. 23-30.

[2] Ibid., p. 28.

[3] Ibid., p. 29.

[4] Ibid., p. 29.

At the same time that citizen participation was evolving in the efforts of the government, it was evolving in other areas of social policy. Most notable of these, perhaps, is the "war on poverty" declared by President Johnson in 1964.[1] This war on poverty was energized by Title II of the Economic Opportunity Act, which provided for the "maximum feasible participation" of the target group of citizens, the poor.[2]

The maximum feasible participation provision was variously intended according to the philosophy of the interpreter and thus differentially implemented.[3] But, in any case, it was a major thrust forward for a principle of citizen participation. Its eventual backlashes, described by Moynihan, do not detract from the fact that many new instances of citizen participation grew out of the governmental support for the principle of maximum feasible participation.

Later in this dissertation we will look in greater detail at the various justifications for introducing citizen participation. We will be especially detailed in reference to the Area Boards of Massachusetts. However, it should be clear that the government itself took a strong stand in the development of some forms of participation and that the various forms of participation are a result of differing observer orientations to the role of citizen participation in a wider process.

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[1]Daniel P. Moynihan, "What is Community Action," The Public Interest, No. 5 (Fall, 1966), 4.

[2]Ibid., 4.

[3]Ibid., 5.

A Systemization of Approaches to Evaluation

There are, in the literature of social science, many statements on citizen participation. It is, however, as Spiegel and Mittenthal report the case: "No one has written extensively about citizen participation though many have written something."[1] Thus there is no thoroughgoing analysis of criteria for the evaluation of forms of citizen participation available. We must look to the many short references and organize the material for ourselves.

It would seem to this investigator that the various approaches to citizen participation we see in the literature fall into one of three broad categories. These categories could be called evaluation models and labeled as follows: (1) a Democratic-Theoretical model; (2) a Political-Revolutionary-Planners model; and (3) a Social Service model. There are no hard and fast rules for classification, but we can, perhaps, illuminate the differences by an exposition of each model.

(1) The Democratic-Theoretical Model

In this model the observer takes a rather theoretical and abstract viewpoint toward citizen participation innovations. He sees them as a basic aspect of the American system of government, an extension of elementary principles, and a rightful process stemming from the people's right to be involved in the decisions of their government.

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[1] Spiegel and Mittenthal, op. cit., p. 4.

To put it another way, the adherent to this model would see new forms of citizen participation as a renewed guarantee of the willingness of the participants to adhere to the terms of the social contract. That is, these participants supposedly have sensed a removal of influence with respect to relevant issues and have become participants in order to redress this decreased influence.

Examples of adherents to this model would include such political scholars as Dahl. Dahl takes an essentially pluralistic view of the conduct of government, believing that it is only through the interplay of many interests that governmental decisions are made. His evaluation is based on his pluralistic criteria for determining the value of political institutions and activities.[1]

Another stream of reasoning which fits into this model is a somewhat more radical sociological approach. It is the viewpoint of Meyers, who says that citizen participation is primarily a modification or reversal of power and authority delegated to governmental figures, executive, legislative and judicial, by their constituencies.[2] According to this approach, the citizen participation of the last few years is a creative reaffirmation of the original social contract. He

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[1]Robert Dahl, "The Ritual of Participation," ed Bellush and Hausknecht, op. cit., pp. 302-311.

[2]William Meyers, "The Social Meaning of Citizen Participation," (Boston: Laboratory of Community Psychiatry, Harvard Medical School, 1970), unpublished mimeograph.

feels that the government had gone too far from the will of the people, and that modern forms of citizen participation reverse that tendency. The examples he uses of this modification and re-assertion include the quasi-governmental boards and councils of urban renewal and community mental health.[1] Meyers' criteria for evaluating a form of citizen participation, then, are based on this theory of the new social contract. He sees the citizen participation as an elementary good because it re-asserts fundamental principles of government in new and relevant ways.

(2) The Political-Revolutionary-Planners Model

The adherents to systems covered by this model could be actual political figures, today's political radicals, or the social planners from some of our prominent schools of social welfare or public policy. The special factor which links these adherents from different backgrounds is their tendency to view citizen participation as a tool for effecting policy changes according to their own bias. These people are activists working on one side of the political process. Their criteria for the evaluation of an innovative form of citizen participation is its likely agreement with their bias and its usefulness in implementing that bias.

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[1] Meyers also contends in this paper that recent trials, including those of the so-called "Chicago Seven," are attempts at judicial reversals of power through non-cooperative participation by individuals being tried.

Examples of individuals with this kind of evaluation models include people like Mayer. Mayer is a social planner with the macro viewpoint of long-term social-structural changes. He wants to introduce major social benefits through manipulation of social systems, and he includes the introduction of citizen participation as one example.[1]

Political-radical individuals who advocate citizen participation as a tool for change include such members of the new left as Tom Hayden, Stokely Carmichael, and even Michael Harrington. But since they would be more interested in other than quasi-governmental forms of participation we need not follow them in detail. Their criteria are that citizen participation bring about specific kinds of changes in society--that it be a good tool for political purposes.

(3) The Social Service Model

We touched, in our discussion of the model cities act above, on a cornerstone concept of citizen participation for those using a social service model; the idea that it takes a positive inducement in the form of participation to draw out the best in a person in need of social services. This is a concept which is sweeping the field of social welfare. It is beginning to show up strongly in such formulations of social programs as the self-help approach in drug addiction treatment

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[1]Robert R. Mayer, Social Planning and Social Change (Chapel Hill: University of North Carolina, 1972), chap. iii.

or housing renewal.[1] It even forms a foundation for recent proposals for a guaranteed minimum annual income to replace existing welfare programs. Examples of other individuals taking this approach would be Marris and Rein.[2] They maintain one benefit of citizen participation is the fact that it helps accommodate the participants to the larger social process of which they are a part.

A second cornerstone concept of this model is the importance of providing social services. Individuals taking this viewpoint see citizen participation as a strong lobby force to support the delivery of direct services.[3]

Each of the three evaluation models above is inexact. Each includes a great many separate approaches, some of which have important features which conflict with the features of other approaches listed in the same type. Nor are the models mutually exclusive. But they are reliable and useful guides to the terrain of evaluation criteria in citizen participation. Looking over the three evaluation models listed above we are struck by the fact that all of the viewpoints reported are the viewpoints of professional scholars or

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[1]Harold W. Demone, Jr. and Herbert C. Schulberg, "The Citizen's Role in Community Mental Health Programs," Paper presented at the Massachusetts Department of Mental Health Leadership Conference, Andover, Mass., October 27-29, 1971.

[2]Peter Marris and Martin Rein, "The Voice of the People," ed. Spiegel and Mittenthal, op. cit., pp. 128-145.

[3]This is a viewpoint often taken in the Massachusetts Department of Mental Health. For example, Dr. Arnold Abrams, Mental Health Administrator of Region III of the Department, made this comment in an interview on January, 1971.

professional participants. None of the individuals listed has carried out any operation to determine the criteria citizen participants themselves use to evaluate citizen participation. The one viewpoint most noticeably missing in the model, as in the entire literature of citizen participation is that of the citizen participants themselves.

The Empirical Research of this Dissertation

It would seem that it is important to know the criteria citizen participants use to evaluate their own activities. Such knowledge would not only contribute to the development of a more comprehensive theory of citizen participation; it would help those responsible for encouraging or opposing new forms of citizen participation to make their judgments.

We plan, in this dissertation, to report on the findings of a study of citizen participants' evaluations of the usefulness and success potential of their form of citizen participation. The empirical test is not broadly representative of all citizen participants' evaluations of citizen participation, but of evaluations which are important. The results will be generalizable to a large number of quasi-governmental boards and councils, and provide real evidence for extended inferences. Other forms of citizen evaluations will not be subject to analysis. But in one sense the non-quasi-governmental form of citizen participation have the advantage of articulate public spokesmen, so we do have at least some idea of their criteria. (See the list of political-radical groups above.)

The formal topic of this dissertation is: "Citizen Participation on Boards: Factors Related to Members' Evaluations of Massachusetts Area Boards." In this piece of research we will focus on the evaluations members of the Area Boards make of the usefulness and workability of their boards. We will try to explain these with characteristics identified on the basis of theory and citizen participations' beliefs. Then, when the tests have been carried out, we will have a firmer understanding of the Area Boards' criteria.

More of the specific empirical research design will be discussed below in this chapter as well as in chapters subsequent to this one. We will present the reasons for expecting various criteria to be valid to the citizen participants and will test them. But before we go further, we will provide a preliminary introduction to the Area Boards of Massachusetts as they existed at the time of the research.

The Area Boards of Massachusetts

The Area Boards of the community mental health system of the Massachusetts Department of Mental Health are quasi-governmental citizen advisory boards. They were approved by the legislature of Massachusetts in December, 1966.

The political history of these citizen boards will be presented in Chapter Two below. Here we note only that they are an indirect result of state responses to federal inducements. The federal government made funds available to the states for planning and

implementing community mental health programs but required that some form of citizen participation be integrated into any federally assisted components. The form that the Massachusetts Citizen participation should take was hammered out in long and difficult sessions among social planners, mental health professionals, politicians, citizen interest groups, and private citizens.[1] It was then written into law by the legislature after it had become the predominant issue in a hotly contested gubernatorial election.[2]

The resulting legislation was the Comprehensive Mental Health and Mental Retardation Services Act of 1966. It provided for the reorganization of the Department of Mental Health and the re-direction of its entire service delivery system. It carved the Commonwealth of Massachusetts into seven regions, and each of the regions into catchment areas giving a total of thirty-seven catchment areas. Whereas the tradition of mental health and mental retardation services had for decades been the provision of services, largely custodial, in state mental hospitals and residential schools for the retarded, the new philosophy called for community-based services. The Department of Mental Health was being asked to forget most of its historical mode of activity and develop a new approach to the old problems.

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[1]Franklin B. Fogelson and Harold W. Demone, Jr., "Program Change through Mental Health Planning," Community Mental Health Journal, Vol. 5, No. 1 (1967), 3-13.

[2]William Curran and Harold W. Demone, Jr., "Translating Mental Health Planning Recommendations into Statutes: The Legislative Process in Massachusetts," Paper presented at the Annual Meeting, American Public Health Association, Miami Beach, October 23, 1967.

The concept of community mental health will be described in more detail in Chapter Two. At this point it is sufficient to know that it is the product of a long and creative effort to change almost every aspect of the care provided for the mentally ill and the mentally retarded. It considers almost all persons receiving service as potentially healthy persons, and it tries to return them to the community at the earliest possible date. Community mental health also insists that the community be closer to the persons being served, and as a necessary component of that perspective it ties citizen participation to the introduction of community mental health.

Any major innovation is likely to meet with confusion and resistance. Change is hard for people to bear, and the uncertainty of not knowing exactly what is expected is painful. Thus it was that there were difficulties in the introduction of the Area Boards of Massachusetts. The mental health and retardation system already had a working system of mental health and mental retardation services, and a fully developed system of citizen participation for the Commonwealth as a whole. There was a strong tradition of citizen participation in the mental health and retardation sphere in Massachusetts. The private associations were powerful at the state level, and in many cases at the local level. There were several types and branches formally organized, usually breaking on the grounds of functional concern (mental health or mental retardation) and geography. But they did exist, and some of the participants in these were opposed to the new forms. Similarly, the professionals in the Department of Mental

Health were accustomed only to the existence of the private associations which had no legal relationship to the Department. They were accustomed to a relatively free hand in the conduct of their profession. Now they would be faced with a legally constituted outside source of observation and a group legally defined with community mental health, a concept not universally accepted in the ranks of the professionals anyway. In other words, there was plenty of potential for problems during the implementation of the new Act.

The Area Board provision of the Comprehensive Mental Health and Mental Retardation Services Act was formally implemented on March 28, 1967, when the thirty-seven boards were empowered to begin functioning. On that day the appointment of approximately 777 citizens became effective and the history of the Area Boards of Massachusetts began.

At the time the research for this dissertation was carried out, the boards had each accumulated three years of experience. Some had been slower in real organization, but all had been empowered and had duly appointed members. The boards had an observable history.

The Research Design: Hypotheses

At this point some three years after the creation of the boards we began to interview some of the members of the boards and a number of persons in a position to know much of their collective histories. We talked to members of the staff of the Department of Mental Health and to members of the private mental health and retardation

associations. We also attended Area Board meetings as observers to see what they were doing and how well they were doing.

During this process of initial investigation of the Area Boards, we found the most pervasive fact to be the sense of uncertainty and ambiguity about the role of the boards, and a general dissatisfaction with the boards as they were operating at the time. Members listed many specific complaints and a number of reasons for their feelings of dissatisfaction. These reasons were often different one from another and it was difficult to tell just what could be done to alleviate the situation. But one thing was clear--the Area Board members in Massachusetts were not happy with their experiment in citizen participation. Something needed to be done, either to correct the situation in the Commonwealth or to design better experiments for the future.

Thus it was that we decided that the citizen members' evaluations of their epxeriences on the boards were a key to the subject of citizen participation in community mental health, and that an understanding of the factors which contribute to those evaluations was highly important. We proceeded to develop a general model which could investigate these evaluations and factors. Now we will try to outline the general model that guided this research and the various hypotheses that have been advanced as controlling factors in the evaluations citizens make of their experiences.

To begin with the general model, we should first point out the necessary concetration on individual members as the primary unit

of analysis. Since we are interested in citizen participants' evaluations of citizen participation and the factors which go into such evaluations, we must have a sufficient amount of information on members' attitudes and perceptions in relation to their boards. Then because, as we will see, the hypotheses concerning members' evaluations depend on members' attitudes and perceptions, we are again directed to individual members.

Out of the early discussions with Area Board members, members of private mental health and retardation associations, and interested professionals, we found no dearth of suggestions (hypotheses) about the causes for the members' negative evaluations which were reputed to exist. There was, however, no consensus on the causes. Each person seemed to have an opinion based on a limited sample of boards and members, and any or none of the explanations could be valid. Furthermore, there were possible theoretical justifications for each of the major suggestions presented.

After eliminating the various suggestions which seemed to be case specific, for example those attributed to the personalities of individuals, we were left with four hypotheses worth testing. These suggestions appeared to be sufficiently independent of one another to be useful explanations, and were testable. We will begin by presenting them as they have been abstracted from observers' comments:

(1) Area Board members don't get anything done.

A frequent complaint of board members, as well as onlookers, is that the Area Boards "don't get anything done." Members feel that, although they meet and discuss topics of

interest, they are unable to put their ideas into practice. They want to see measurable activity or observable results from their work but see only their time being sunk into the system. With board members possessed of high skills and the motivation for high achievement, this is directly frustrating.[1] Several members claimed this as the primary reason for member resignations from the boards.

(2) The boards are not doing the things they should.

In the first hypothesis above we were concerned about objective accomplishments of boards. Now we see that some observers are concerned with the extent of enactment of the role of the boards. That is, some observers feel that members react negatively to the actual, implemented role of their boards. This hypothesis is similar to the first in some ways, but differs in being a response to an aspect of role, not objective results.

(3) The role of the Area Boards is not clear.

In the case above, people are saying that the boards do not have an adequate record of accomplishment. They are saying that accomplishments and achievements are too limited. In this case they are saying that they aren't even sure what the boards are supposed to be accomplishing. They are saying that the purposes, powers and goals of their boards are uncertain.

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[1]This formulation is directly attributable to Area Board members. However, we have been unable to test the idea insofar as it concerns high skills and high motivation; the data do not provide the information for such a test.

(4) Everyone has a different idea about the role of the board.

Several observers expressed the feeling that there were many different expectations of role performance bearing down on the boards. Many of the statements of this were particularistic, pointing to components of the Department of Mental Health or private associations. But many individuals did predict role conflicts from one source or another.

For each of these four hypotheses there is some form of scholarly support. Each hypothesis has theoretical justifications which suggest the possibility of the hypothesis as applied to the Area Board situation.

The scholarly support for these four hypotheses will be elaborated in the chapters in which each is tested. In Chapter Four the more general theoretical background of the role of the Area Boards will be presented. At this time we will only mention these supports in passing:

(1) Area Boards Don't Get Anything Done: The Achievement Approach.

Caplow, who has done a great deal of work in assessing factors related to positive evaluations of employees and of organizations, suggests that the failure to accomplish things is a cause of negative evaluations in organizations.[1] High

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[1]Theodore Caplow, Principles of Organization (New York: Brace and World, Inc., 1964).

evaluations are, he says, positively correlated with achievements.[1]

(2) The Boards are Not Doing What They Should: The Role Enactment Approach.

Theoretical justification for this hypothesis is more difficult to express than is the case in previous hypotheses. It has one expression in the work of Etzioni. He maintains that positive "cathetic-evaluative orientation" is deeply tied to involvement.[2] We think he means by this that individuals' evaluative response to their organization is a correlate of the level of integration (in his terms) with the goals and purposes of the organization. Or, in our terms, with the members' perceptions of the role enactment of their board.

(3) The Role of Area Boards is Not Clear: The Role Ambiguity Approach.

Several social scientists working with boards of poverty organizations have noted the corrosive effect of role ambiguity in members' responses to their board experiences. Frank Riessman argues that "one of the greatest problems experienced by the non-professional is role ambiguity or lack of role identity."[3] Zurcher quotes Reissman on this view and

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[1] Ibid., p. 122.

[2] Amitai Etzioni, "A Basis for Comparative Analysis of Complex Organizations," A Sociological Reader on Complex Organizations, ed. Amitai Etzioni (New York: Holt, Rinehart and Winston, Inc., 1961), p. 64.

[3] Louis A. Zurcher, Jr., "Poverty Program Indigenous Leaders: A Study of Marginality," Sociology and Social Research, Vol. 53, No. 2 (January, 1969), 147-162.

carries it on to an empirical test on a small sample of poverty board members.

(4) Everyone Has Different Ideas about the Role of the Boards: The Role Conflict Approach.

Gross et al. have developed the concept of role conflict to a point of substantial refinement in Explorations in Role Analysis.[1] These men were writing about the school superintendency role, but many of their hypotheses would seem to be applicable to Area Boards. For example, they hypothesize that individuals exposed to role conflict will "derive less gratification from the occupancy of their position than position incumbents who do not perceive they are exposed to role conflict."[2] And we translate this into the hypothesis that role conflict can have a significant impact on the members' evaluations of their boards.

The Research Design: Data Collection

There were three distinct processes of data collection used in this research. The first included general interviewing of individuals with an interest in the Area Boards. We spoke to some members of the boards, referred to previous research on these boards, looked at

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[1] Neal Gross et al., Explorations in Role Analysis: Studies of the School Superintendency Role (New York: John Wiley & Sons, Inc., 1958).

[2] Ibid., p. 295.

internal documents concerned with the boards, and interviewed members of the staff of the Department of Mental Health. Secondly, we interviewed, with lengthy structured interview schedules, all of the presidents of the thirty-seven Area Boards and followed up by interviewing vice-presidents by telephone. Thirdly, we mailed all of the members of Area Boards in Massachusetts--excluding the members of one board who asked to be excluded, discussed in the next chapter--copies of an eight-page questionnaire.

Data from the first source were recorded in the form of notes taken by participants in the interview. They were used only to assist, as background information, in the construction of the explanations offered above and in the formulation of a general model for research. Most of these data consisted of the impressions of specific individuals about the operation and the framework of operation of the Area Boards, or about the operations of the various groups that are important parts of the mental health and retardation system. Data from the second source were recorded in detail at the time of the interviews and transcribed into typed records. These records were carefully coded according to two different coding schema and put on computer tape for analysis. The content of these interviews included facts about the presidents of the boards as well as copious detail about the operation and accomplishments of the Area Boards. The data from the third source were coded and put on computer tape for analysis. They will be discussed in detail in other places, since they are the primary data for this research. But, in short, they included questions

about the attitudes, opinions, and perceptions of Area Boards as they related to the experiences of the members on the boards.

Taken together, the data described above include general information about the whole mental health and retardation system in Massachusetts, information about the boards themselves and their structure, and information about the individual members of the boards. Theoretically, it would have been possible to approach the research from any of these points of view. However, because of the formulation of the question in terms of the responses of citizen members to their experiences, we chose to take the individual members of boards as the primary units of analysis. This does not mean that the general information on the system or the data collected on the boards themselves were not used. They were. But all of the analysis is directed toward determining why members of the boards, as a class of individuals, have responded to their experience as they have.

CHAPTER TWO

BACKGROUND, STRUCTURE, AND COMPOSITION OF AREA BOARDS

Capsule History

A complete history of Area Boards in Massachusetts would be detailed and complex. It is necessarily tied to the history of the volunteer movement, the history of state mental health and retardation care, and the efforts of the federal government to stimulate and guide the further development of mental health and retardation services. But the complete history is not necessary here. We are interested only in that part of the history that bears directly on the creation of Area Boards or on the nature of the conditions in which the boards carry out their role. Thus we will look first at the environment that produced Area Boards and then at the sequence of events that led up to the legislative act establishing the boards.

The governmental tradition in Massachusetts is one of strong and efficient, if small and elite, citizen participation in the policy side of public affairs. It is one of substantial centralization of state administration in Boston, but a great amount of local

autonomy for governmental units throughout the state.[1] And it is one, common to most of the states today, of reacting to federal initiatives for the introduction of new services and facilities. These factors set the stage for any discussion of the background of Massachusetts Area Boards.

Citizens of different types have been active in the area of mental health from an early stage in the development of modern services. Citizen groups consisting of businessmen and professionals were the leading exponents of reforms in the hospital system existing in the late 19th and the first half of the 20th centuries. In the last twenty-five years or so such citizen groups have been active in the creation and maintenance of local facilities for mental health and retardation care. They have been responsible for mental health and child guidance clinics, half-way houses, and assistance programs of all kinds. In many, or perhaps most, of the community facilities set up before the passage of federal funding support, citizen groups provided the money to establish facilities, and pay for upkeep, equipment, and support staff. In other words, they arranged to provide all of the necessities before the state would agree to contribute a professional staff.

While the citizens, organized now in private associations, were raising money to develop local facilities, the state agencies charged with the responsibility to provide mental health and

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[1]The Medical Foundation, Inc., Mental Health for Massachusetts, A Report Prepared by the Massachusetts Mental Health Planning Project (Boston: The Medical Foundation, Inc., 1965).

retardation services were developing the state hospital system. By the time the Area Boards were established in 1967, they had created twelve state mental hospitals, five schools for retarded children, a hospital for epileptics, and a hospital for the aging. Each of these facilities was under the supervision of the state and consolidated under the Department of Mental Health in 1967.

The formal conjunction of private volunteer and state efforts has occurred in a number of ways. At one level the Division of Mental Hygiene of the Department of Mental Health, the agency dealing with the private groups in the creation of the community facilities described above, established a contractual relationship to the private citizens involved. They worked with area mental health associations and signed contracts for services. These associations then appointed members to sit on advisory boards to serve the clinics they supported. On another level the citizens have formed statewide mental health and retardation associations called, respectively, the Massachusetts Association for Mental Health and the Massachusetts Retarded Children's Association. These associations, often overlapping the membership of the area mental health associations, have in turn worked in conjunction with the state Department of Mental Health. However, there are many cases of strong conflict between the state and area level associations, and between mental health and retardation volunteers. On still a third level, citizens have served on the Boards of Trustees of state hospitals. And on the fourth and final level, they have

served on numerous study and planning commissions in the field of mental health and retardation.[1]

The federal government has also been an important factor in the background of the Area Boards. In fact, it has probably been the central thread that runs through the history of events leading up to the final legislative act establishing the boards. The federal history really begins in 1946, with the creation of the National Institute of Mental Health (NIMH) to serve as a focal point for mental health problems with national importance. NIMH has become more and more involved with the provision of services by the state, and it has supported important studies of conditions and planning commissions that have resulted in major innovations. For example, in 1955, the Mental Health Study Act was passed to look into the conditions of mental health care in the United States. Dr. Jack Ewalt, then Commissioner of Mental Health in Massachusetts, was appointed chairman of the study group that investigated the resources and programs of mental health and illness. In December of 1960, this commission published a report that received widespread attention. Action for Mental Health reported the extreme need for further action to improve existing conditions.[2]

In 1963, responding in large part to the turmoil created by Action for Mental Health, President Kennedy included $4.2 million for

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[1] Demone and Schulberg, op. cit., p. 2.

[2] Joint Commission on Mental Illness and Health, Action for Mental Health (New York: Basic Books, 1961).

comprehensive mental health planning in the Health, Education and Welfare Department budget request for grants-in-aid to the states. Some of this money, a total of $175,300 came to Massachusetts for a two-year "Mental Health Planning Project," and a "Mental Retardation Planning Project."[1]

In the same year, Congress passed President Kennedy's proposed "Mental Retardation Facilities and Community Mental Health Centers Construction Act" (Public Law 88-164). This act provided funds for the construction of mental health and retardation facilities. These funds were supplemented later in the same year to include special staffing provisions to assist in the initial implementation of the new facilities. Together these two acts became the backbone of the new community mental health effort. The restrictions and inducements of this categorical grant to the states shaped the system that came into being. They called for citizen participation and involvement and became, consequently, a primary force behind Area Boards.

Plans for taking full advantage of the new federal programs were made through the Mental Health Planning Project. This project, which became an important exercise in citizen participation, conducted a careful review of the needs and resources of the state and listed a comprehensive set of recommendations for further activities. The planning project was placed in the hands of The Medical Foundation, Inc., a private, non-profit organization for research and education in the field of health. This group organized over three hundred

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[1]The Medical Foundation, Inc., op. cit., p. 6.

prominent individuals from a wide variety of professions, representing a wide and comprehensive selection of different factions and interests, and coordinated their activities with an interdisciplinary staff in the areas related to mental health and retardation. The Medical Foundation was chosen to perform this critical function, in contrast to its performance in other states by state agencies, because it was felt that the Foundation could best provide the fresh approach that was required and best avoid the bias of vested interest.[1] Thus a broad and representative collection of citizens carried out the work of planning for a new mental health and retardation system in line with the proposed purposes listed in the study grant proposal: "(1) to develop a system that would stimulate greater community initiative and participation in the long-term solution of mental health problems, (2) to develop a comprehensive master plan for coping with the community's mental health problems, and (3) to establish a permanent mechanism within the Department of Mental Health."[2]

Once the planning project completed its work and reported back to the state, development of legislation commenced. The planning project had included thirty-eight members of the legislature. By coordinating the activities of the project and the committee structure of the legislature, much of the legislative preparation was already accomplished. Thus the recommended legislation was ready for action in 1966.

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[1] Ibid., p. 7.

[2] Ibid., p. 6.

The planning project had prepared both detailed recommendations for changes in the administrative structure of the Department of Mental Health and a well-developed model for citizen participation in the new structure. The report included a suggested form for regionalization of the Department's services and the creation of thirty-seven areas in conformity with federal plans. There had been a minority view on the planning project about the form of citizen participation in these thirty-seven areas--the view that the citizen boards in each area be granted substantial autonomy and legal power to raise and disburse their own funds.[1] The accepted majority viewpoint was more restrictive and placed the boards in the state structure.

On December 28, 1966, the legislature, called into a special session by Governor Volpe especially for this purpose, passed the legislation that implemented the planning project proposals. The recommendations of the planning project, modified by the legislature, became Chapter 735 of the Acts of 1966: An Act Establishing a Comprehensive Program of Mental Health and Mental Retardation Service.

The Structure of Area Boards

Chapter 735 of the Massachusetts laws is a "master plan for a new delivery system for mental health and retardation care."[2] As

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[1]Interview with Dr. Harold W. Demone, Jr., Director of the Massachusetts Mental Health and Retardation Planning Project, November, 1971.

[2]Massachusetts Department of Mental Health, Your Area Board: A Challenge and a Trust (Boston: June, 1967), p. 1.

such, it outlines a new structure for the Department of Mental Health, a structure diagrammed in Figure 1 below. The structure is based on the creation of seven regions which cover the entire state and are divided on the basis of population and need. These regions completely encompass the thirty-seven catchment areas, with an average of five areas in each region. All the state mental health and retardation services are now administered through this hierarchy.

The Commissioner of Mental Health sits at the top of the new structure and reports directly to the Governor. He is supported by five Assistant Commissioners with responsibility for specified functional areas, a Deputy Commissioner who assists him, and three advisory councils to provide him with a wider perspective in their respective areas of concern. Each of the seven regions has a regional administrator for mental health and one for mental retardation. These men have regional offices from which they carry out their responsibilities at the regional level, and they meet regularly with the other administrators and a representative of the Commissioner, usually the Deputy Commissioner. There is a slot set aside for an area director for each of the thirty-seven areas, but at this writing these have not been funded by the legislature. Presently, the responsibilities of this set of positions are filled by acting area directors, or by funded associate area directors. However, the acting area directors are most often men in other positions of responsibility in the state mental health or retardation system and have only part time for their area activities.

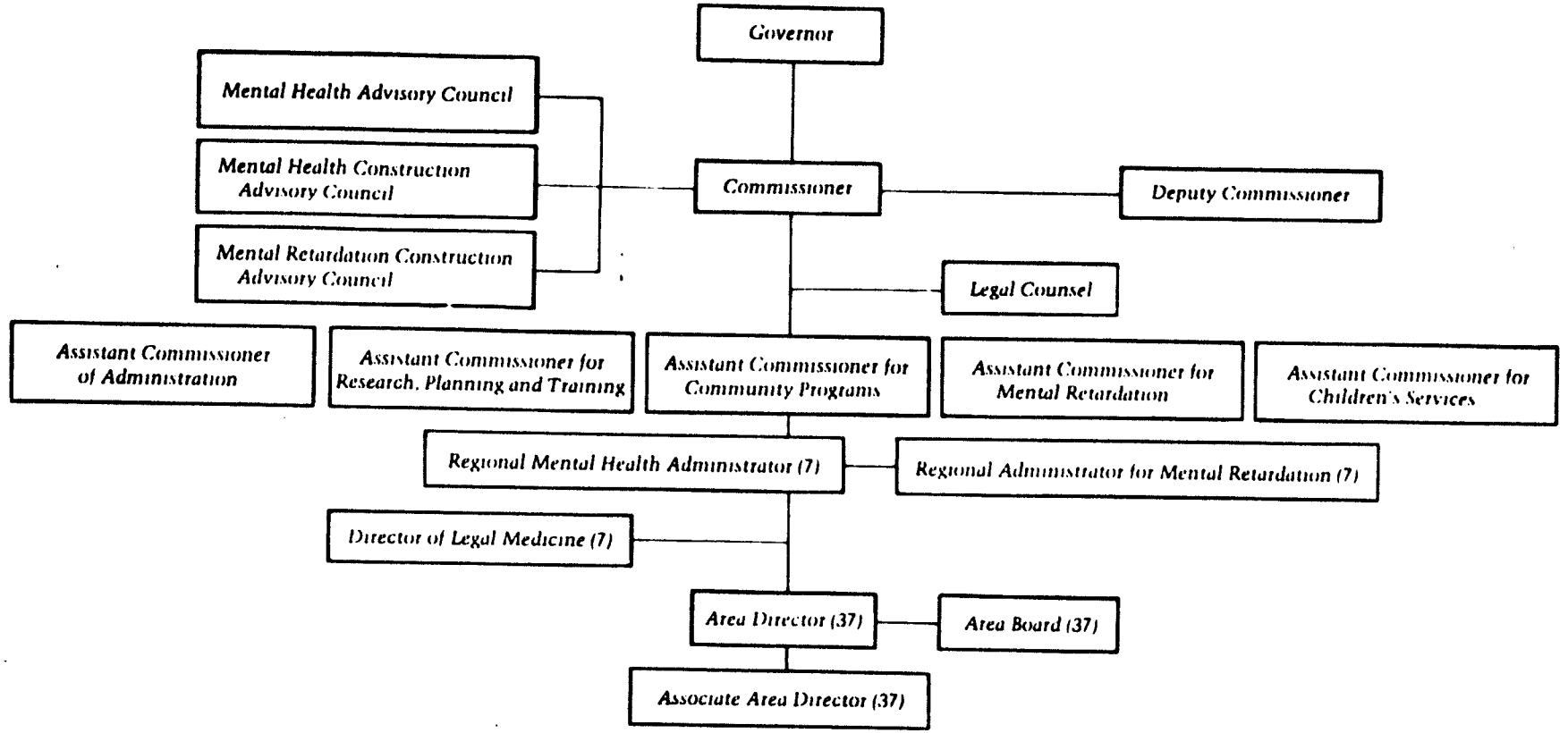

Figure 1

STRUCTURE OF REORGANIZED DEPARTMENT OF MENTAL HEALTH
March 28, 1967[a]

[a] Ibid., p. 10.

The thirty-seven areas were established in inferred conformity with the wishes of the federal government. They were designed to meet federal expectations that each catchment area have a kind of geographical unity and serve a population of 75,000 to 200,000 people. In each area there is supposed to be a natural gravitation to the area services, although there is no prohibition against some overlap in client pools.

Area Boards themselves are made up of twenty-one citizens selected by the Commissioner of Mental Health in accordance with legally established rules. A selection committee was appointed by the Commissioner to provide him with a list of fifty names in each area from which to choose the original twenty-one members for each board. The names were supposed to include persons who have "assumed roles of community leadership and responsibility, and demonstrated . . . special interest in the field of mental health and retardation."[1] These twenty-one members must meet other requirements also. They must be chosen so that:

> Two-thirds of the members live in the area (and the others must either live or work there);
>
> Four of the members are also members of the mental health or retardation associations of their area;
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> Each community in the area will be represented, if possible; and
>
> No Area Board member is also a member of the staff of the Department of Mental Health.[2]

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[1] Ibid., p. 31.

[2] Ibid., p. 31-32.

Standard terms of office for Area Board members are three years, with the possibility of one renewal of appointment. However, during the initial period the length of terms was adjusted so that one-third of the members were appointed for one year, one-third for two years, and one-third for three years. In this case the renewal for a second term was considered almost automatic. When terms come open, the boards recommend two eligible citizens for each opening and the Commissioner selects one.

Once established, the Area Boards are encouraged to approva a written set of organizational rules and procedures and a format for these rules and procedures is provided for them. They are thus encouraged to elect a president, vice-president, secretary and treasurer. Boards are also encouraged to establish working committees and to appoint chairmen for these committees.

Meeting places are provided by the state, but the development of other support services is largely the individual responsibility of the Area Boards. Some of the necessary support is provided through relations with area services and institutions in the mental health and retardation system, but the ability of each board to obtain such support is dependent upon its diplomatic powers.

The Legal Role of Area Boards

The basic structure of Area Boards is a matter of law. The legislature listed many duties and responsibilities of Area Boards and granted the Department of Mental Health the right to supplement

these with subsidiary specifications as necessary. Thus the formal role of the boards is a complex mixture of assignments and powers worked out in response to changing conditions within the constraints of law. The resulting picture is none too clear, and there are many areas of specific and general ambiguity.

The enumerated duties and powers of the Area Boards are spelled out in Chapter 735 of the Massachusetts Code. An abbreviated version of these enumerated expressions of the role of the boards is as follows:

(a) to act as the representative of the citizens of the area;

(b) to advise regarding local needs and resources in the development of comprehensive mental health and retardation services;

(c) to advise in the recruitment and selection of the area director and associate area director ... provided, further, that all such appointments shall be made subject to the provisions of chapter thirty-one;

(d) to review and approve the annual plan and to review and make recommendations concerning the annual budget for the comprehensive mental health and retardation services of the area;

(e) to review arrangements and contracts for programs and services which are a part of the program of the area but which are not conducted within commonwealth-operated facilities;

(f) to consult with the commissioner in personnel recruitment and appointment policies, in the establishment of program priorities for the area, in admission policies for all facilities and services, and in policies regarding relationships with other agencies and organizations;

(g) to communicate with the mental health advisory council, established under section sixteen, to discuss any matters concerning the area program;

(h) to receive and administer any gift or bequest ... in the interest of the area program of mental health and retardation services ...;

(i) to receive funds under contracts or other agreements from community sources ... services in collaboration with such municipal or other community or private agencies providing cooperative or complementary services;

(j) to hold regular meeting in each year and to convene special meetings on the call of the president, or ten members of the board, or the area director, or the regional mental health administrator. ...;

(k) to elect from their members annually a president and such other officers as they deem appropriate. The area board shall adopt rules for their proper organization and for procedures at meetings. Such rules and any subsequent amendments thereto shall be submitted to the commissioner for approval.[1]

These powers might appear at first glance to define the role of the boards fairly clearly. But on closer observation it becomes clear that their form is restrictive and does not often include final authority in any area of concern. For example, Area Boards have the power to "review and approve" the annual plan and to "review and make recommendations" concerning the annual budget. But they are not granted the power to enforce their opinions. In the views of many of the Area Board members, they are assigned a responsibility without a corresponding power.

This impression of almost ritualistic granting of authority is further encouraged by such statements as, "Over and above your legal responsibilities, however, is the more subtle, but equally important role you can assume as the strong citizen voice for good mental

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[1] Ibid., p. 33.

health and retardation programs in your community."[1] And again, "Now citizens such as you--labor union members, lawyers, clergymen, housewives, doctors, businessmen, teachers--have a legal responsibility in planning and effecting comprehensive community mental health and retardation programs."[2] Then finally, "Over and above your legally defined role, your Area Board has the more subtle responsibility for influencing the quality and extent of the program to be established in each community."[3]

The Department of Mental Health's View of the Role of the Boards

The only direct evidence on the Department's view of the role of the boards comes from its publication, Your Area Board: A Challenge and a Trust. In this document the Department presents its interpretation of the law of Chapter 735 and its understanding of the context. Your Area Board presents the brighter side of the picture to incoming members, and it is intended to be a persuasive document. It admits, under a section entitled "The New Role of the Citizen," that "in the past, participation by citizens often was considered interference by the professionals."[4] But it asserts that "now, citizens are enjoined by the law to help provide for the needs of the

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[1] Ibid., p. 30.

[2] Ibid., p 30.

[3] Ibid., p. 35.

[4] Ibid., p. 31.

mentally ill and retarded."[1] And it continues to emphasize the challenge of citizen participation and the rewards that can be expected from this new experiement in institutional structure.

The question of the more basic meaning of Area Boards to the Department is perhaps summed up as follows: "The establishment of citizen advisory boards . . . acknowledges that without strong citizen support and participation, the new Community Mental Health and Mental Retardation Services Program cannot achieve its full potential."[2] Thus the Department makes it clear that it believes the boards to be primarily advisory and that it views the boards as an important link to the public. It is evident that every bureaucracy needs a constituency for supportive purposes, and that these constituencies are best and most effective for the agency when they are organized and articulate. The private associations have always provided that constituency support for the Department, and the Department has always dealt with the private associations with mixed feelings of gratitude and disapproval. The creation of Area Boards potentially disrupts the relations established with the private associations and introduces a new form of public contact.

The link between the Department and the public as it is seen by the Department has several aspects. Among these is the process of interpreting community needs, or expressing the demands of the community to the Department for their consideration. Every service agency

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[1] Ibid., p. 31.

[2] Ibid., p. 2.

must have some form of feedback to facilitate the most effective delivery of services. Likewise, it has a strong need to build up public support for the work to be accomplished and to generate public support for the maintenance or supplementation of financial support. Perhaps this perception of the role of the boards is best visualized as a bridge. The Department wants to hear about the needs of the community and at the same time maintain a strong image with the public.

There is also indirect evidence of the Department's perceptions of the role of the Area Boards. This comes from two separate sources. The first consists of interviews conducted by this investigator among the various administrators in the central office of the Department. These interviews were, for the most part, conducted in the expectation that the views of the respondents would remain anonymous.[1] The other source is unsolicited comments from Area Board members about the experiences they have had in dealing with the central Department of Mental Health.

The first of these streams of information can be reported only in a general form so that respondents cannot be identified. It is complicated by the fact that much of the information had to be sifted out of rather elaborate explanations. For example, there was a reluctance to identify precisely the limits of the boards' powers and authority. One of the more highly placed Department representatives felt that it should be left entirely to the boards to determine the

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[1]Officials of the Department reported that the role and function of Area Boards was a sensitive topic and they did not feel that the importance of being able to attribute statements to individuals was worth the attendant political risks.

limits of their powers. He felt that only through a fully isolated struggle with themselves could boards define their role. He was willing to let these governmental bodies define their own role in much the same way that private volunteer associations defined theirs. Thus they could have the power that they were able to generate through their own abilities to organize and present their opinions to the other sources of authority. He himself was unwilling to appear before the boards or to answer questions not insistently addressed to him.

It is impossible to say whether this attitude reflected a covert hope that the boards would develop their strength to the point that they would be a powerful force in the politics of mental health and retardation, or whether he hoped that they would die on the vine. He did express the opinion that there was substantial resentment of the boards in the Departmental hierarchy and that there were those members of the Department who hoped that the boards would fade away. Further, he thought that the legislature was in itself an important form of citizen participation, and he seemed unsure whether the boards were necessary.

Another official, also highly and critically placed in the Department, seemed to feel that the citizens were not technically competent to handle the job they were being asked to perform. He seemed to think that even a restricted advisory role could cause more trouble than it was worth and that there was really no need for citizen advisory boards. The impression was left with this investigator that the official was not at all sympathetic to the development of Area Boards in Massachusetts.

The second stream of information on the informal departmental view was that derived from talks with citizen members of boards, and the comments they attached to the questionnaires. The general consensus seemed to be that the Department looked on the boards as a restriction on its freedom of movement; or, at best, as a necessary public relations gimmick. Data will be presented at a later time about the citizen view of the Department of Mental Health and the role the citizens think the Department wants them to play. But the general, unsolicited comments were almost entirely critical of the lack of support for the growth and development of the Area Boards.

Personal Characteristics of Area Board Members

The provisions for initial recruitment and regular replacement of Area Board members in Massachusetts include a bias in favor of a single type of citizen--the interested, civic-minded community leader.[1] By asking for the names of citizens who have already demonstrated leadership and responsibility in the community and who also have a special interest in mental health and retardation, the Commissioner is introducing prejudice in favor of an upper-middle class person of middle age who has a good education and civic spirit. He is probably also increasing the odds of getting well-to-do businessmen and professionals.[2]

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[1] See above the section on "The Structure of Area Boards." These provisions stem from powers delegated by the legislature to the Commissioner.

[2] Lester Milbrath, Political Participation (Chicago: Rand-McNally, 1965).

In practice, this has turned out to be the case. The Area Boards of Massachusetts are comprised largely of individuals with good incomes, good educations, good jobs, and many years of residence in the community. Just over one-third of the members are women. Most of the members are married and have children. The median age is forty-nine, and only eight of the 440 members who returned questionnaires are under the age of thirty.

For most of the members, participation on civic boards is not new--in many cases it is only one of three or four, or even seven or eight boards to which they belong. Members report belonging to business boards, boards of service clubs and agencies, and even other mental health and retardation boards. The typical Area Board member is experienced in citizen participation before he becomes a member. Or, to put it another way, the Commissioner's criteria for member selection have usually been carried out.

Area Boards and Community Mental Health[1]

It is difficult to separate the concept of Area Boards from the theory and practice of community mental health. Community mental health was a significant part of the inspiration for the passage of Chapter 735 of the laws of Massachusetts and is deeply embedded in that law. Area Boards are charged with "a major responsibility for

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[1]Richard H. Williams and Lucy Ozarin, eds., Community Mental Health: An International Perspective (San Francisco: Jossey-Bass, Inc., 1968).

carrying out the intent . . ." Chapter 735.[1] Thus it will be apprioriate to provide a brief sketch of this important movement, since it would be difficult to understand the Boards without this background.

First and foremost, community mental health is a contrast to the traditional state hospital system for the mentally ill and state schools for the mentally retarded. The state hospital and school system was a great innovation in the care for the mentally ill and the retarded in the 19th century, when it was created by such crusaders as Dorothea Dix.[2] Replacing the less humane institutions of alms houses and of official neglect, it offered a "moral treatment" for these disadvantaged people.[3] But by the 1950's, conditions in the institutions deteriorated relative to then current knowledge, advances, and possible services. The famous report, Action for Mental Health, declared the state institutions bankrupt as treatment programs.[4] It declared that the isolated custodial treatment of state institutions was not humane and not therapeutic. It called for an entirely new approach in which individuals needing service would not be pulled out of their communities and placed for long periods of time in institutions too far, even for regular family visits.

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[1]Massachusetts Department of Mental Health, Your Area Board, op. cit., p. 2.

[2]Leopold Bellak, ed., Handbook of Community Psychiatry and Community Mental Health (New York: Greene and Shatton, 1964).

[3]Joint Commission on Mental Illness and Health, op. cit.

[4]Ibid.

A precise definition of community mental health is impossible, for community mental health is many different things to different people. Many of its adherents are convinced that it is a giant revolution in thought and practice and the only hope of help for the mentally ill. Its detractors say that it is not so new or different at all, and that it is merely a financial drain on an already underfinanced system of care and treatment. So what can we say to elucidate the movement in a short space?

First of all, we can say that community mental health is three separate things: It is an ideology concerning the etiology of mental illness; it is a philosophy of treatment; and it is an innovative model for the delivery of mental health and retardation services. It is many things at one time. But it is also a movement, and it absorbs practitioners who are relatively unconcerned about the etiological, philosophical, or even organizational theories involved, but who nonetheless join with movements. It also passes some people by who adhere to the theories and philosophies but do not join movements. Community mental health is a very complex entity.

Secondly, we should describe the official ideology of the movement, starting with the theories of the causes of mental illness and going on in turn to the philosophies of treatment and structure. We will begin with etiology.

Practitioners of community mental health would probably agree in placing the primary blame for mental illness and emotional disturbance on the environment of the person showing "symptoms." It

would focus on the conflicts produced by cultural, social, and interpersonal differences and dislocations. According to this viewpoint, mental illness is an adaptive failure of an individual who is clearly part of a larger social context. Community mental health tends away from putting the blame on the internal dynamics of individuals and puts it in the framework of relevant personal contacts. This approach is also referred to as "social psychiatry" or "community psychiatry."[1]

Some practitioners would carry this orientation to its logical extreme. They would say that the mentally ill are not ill at all, but social deviants. They would say that we use the designation of "ill" to place them in a category which subjects them to pressures to change their socially deviant behaviors. Still others are at the opposite extreme and stress the designation of "ill." These individuals would say that people who exhibit the signs of illness are the product of a hostile environment and are as much ill as the patient who suffers a heart attack or develops flu. But whatever the emphasis of the practitioner, the belief is that the patient is "ill" or "not ill" in the context of society, not ordinarily as a product of deterioration of the brain or an act of God.

The significance of the theories of the causes of mental illness shows up in the philosophy of treatment which results. Adherents to the community mental health ideology believe that insofar as

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[1]Leigh Roberts et al., eds., Community Psychiatry (New York: Doubleday Anchor, 1969).

the society is the cause of the patient's problems, the treatment is also a societal affair. They believe that, if the patient's problems grow out of interactions in his community, the worst treatment is to remove him from the community. They would prefer to work with the patient to teach him to cope with the stresses and strains which caused him to develop his symptoms in the first place. While they would help to reduce the environmental stresses so that they would no longer overwhelm the patient, they would also feel that excessive isolation could only make it more improbably that the person would return quickly to a "normal" life.

More basically, the advocates of community mental health believe in the "curing" of patients. Given this belief in the "curability" of patients, the philosophy of community mental health begins to point toward a theory of treatment and of the organization of services. For example, it is a basic tenet of community mental health that much of mental illness can be prevented by the reduction of environmental stresses and the early identification of signs of stress among individuals. Treatment can then be provided early in the illness and the course of the illness reduced. By the proper development of rehabilitation and aftercare services, the recurrence of the illness can be eliminated.

We can see, then, that in terms of services the community mental health ideology means an orientation different from the traditional mode of services--the state hospitals and schools sprinkled with child guidance centers. It means community-based

services designed to respond quickly to observed needs in the community. It means services which are comprehensive in scope and purpose; services which stretch from prevention through follow-up. Furthermore, it often means twenty-four hour emergency or "crisis intervention" services and services tied directly to other available community services.

Due to its broad scope and purpose, community mental health has also meant other things to the mental health professions. It has meant the increased use of social workers, educators, and community organizers. Community mental health has meant that the psychiatrist is no longer the sole key to psychiatric help, but is a member of a team. Finally, it has led to the development of a new kind of mental health worker, the so-called "paraprofessional." The paraprofessional may not even be a college graduate, but he or she is selected because of natural skills and special cultural knowledge useful in helping people with problems. Some of these paraprofessionals are trained in the new "mental health technician" programs and in two-year colleges. They operate under the direction of regular professionals, but by their very existence they set new tenor for mental health services and indicate some of the flavor of the community mental health movement.

CHAPTER THREE

DATA COLLECTION AND METHODOLOGY

All of the data for this dissertation were collected under the auspices of the Citizen Participation Project of the Laboratory of Community Psychiatry, Harvard Medical School. In August, 1969, the Laboratory of Community Psychiatry received a grant from NIMH to conduct research on citizen participation in Massachusetts, particularly on the Area Boards of the mental health and retardation system. The primary thrust of the grant was to provide an initial base of information and analysis to be used in turn to aid the Area Boards in improved functioning. The Citizen Participation Project team defined the effort more precisely as a series of research efforts, including several case studies and a state-wide survey, leading to a series of educational seminars for Area Board members and employees of the Department of Mental Health.

This investigator initiated his research independently of the Citizen Participation Project, defining his topic and preparing his hypotheses, but soon discovered the existence of the Citizen Participation Project. He also found that previous investigators had

surveyed Area Board members, somewhat clumsily, and that members were reported to harbor resentments toward research not promising to be of use to the Area Boards. Thus in discussions with the Citizens Participation Project team, it was decided that the dissertation effort and the Project effort could be closely coordinated for mutual benefit, and an alliance was formed. The Project assumed the research costs of the dissertation, and it was decided that any information collected by this investigator or the Project team would be available to each other.

As a result of this collaboration most of the initial interviews in the Department of Mental Health and with Area Board members were conducted jointly. Instruments for data collection were jointly developed, and research designs formulated to be complementary.

The collaboration between this dissertation research and the Project worked well throughout. Investigators gained through the interactions, and the Area Board members appreciated the economy of contact and the cooperation exhibited. Thus there were not only professional advantages to all concerned, but in addition Area Board member cooperation with the research effort was greatly increased.

The Design of the Study and the Choice of Instruments

It was the original plan of the Citizen Participation Project team to conduct several case studies among the boards, and to talk to various members of the Department of Mental Health staff. It was the

original plan of this study to talk to various members of the Department of Mental Health staff and conduct interviews with a sample of Area Board members. Both plans were modified as the research design developed. The Citizen Participation Project team decided to expend more energy than anticipated in the selection of case studies, and to collect data that would allow them to make more comprehensive statements about the Area Boards of Massachusetts. They also decided, after interviews conducted with members of the staff of the Department in conjunction with this investigator, to leave this sensitive area of research until the end and concentrate on the boards themselves. In a like manner this investigator decided to minimize the Departmental interviewing and exert more effort in the collection of members' responses to questionnaires. Thus the focus of the joint study became the Area Boards and their members.

The first stage of the research, then, became the design and conduct of in-depth interviews with all thirty-seven Area Board presidents. An instrument was developed to insure the collection of certain basic data for every board, and to probe in some depth for additional information of special interest. The information ranged from statistics on the operation and experience of the boards to material reflecting issues and policies affecting them. Two members of the staff participated in each pre-scheduled interview, one taking comprehensive notes on prepared recording sheets, and the other asking questions and probing for further responses from question cards.

Comprehensive pre-testing and unstructured interviewing of past and present board presidents made this an effective instrument. All thirty-seven presidents agreed to meet interviewers, and all interviews were completed. Then, in a subsequent operation, board vice-presidents were contacted by phone and interviewed for the purposes of supplementing information and validating data already received.

The second stage of the research was the development and application of the survey of board members. The Commissioner of Mental Health, the Assistant Commissioners concerned directly with boards, and all of the Regional Administrators were contacted to obtain their approval for the approach to Area Board members. They all agreed, and some reviewed the instrument in various stages of its development.

It was decided to request a response from all Area Board members in Massachusetts, of whom there were approximately 770. The rationale for this approach to the total population of Area Board members was simple. A large number of responses are needed in order to conduct an analysis of relations between variables and still expect to be able to control for the effects of others. This is especially true in the case where differences in response may be small, or when it is desired to employ a wide range of response alternatives for respondents. Furthermore, the expectation derived from initial interviewing suggested that many board members might have resigned or be unwilling to respond.

Having decided to approach all Area Board members in the state, it was necessary to select a mail questionnaire as the instrument. Direct interviewing on the scale proposed would have been prohibitively expensive. Mail questionnaire techniques were assessed to determine their ability to collect the specific information sought, and were judged acceptable. They would increase the risk of non-response, being less personal and less flexible, but the additional number of potential contacts still outweighed the potential loss.

Drafting the Instrument and Operationalizing the Variables

Information requirements for the instrument included background on individual members, their opinions and perceptions, and their reports of their experiences as board members. A letter requesting participation in the research was written, and copies bearing an individualized salutation and address were prepared. At the same time an eight-page questionnaire was written, reviewed and pretested on selected Area Board members. Then modified, it was typed and reproduced for distribution.

Each questionnaire bore an administrative code number, and respondents were assured that they would not be identified as individuals to anyone not on the research staff. Then the questionnaire was presented in the simplest form possible. Boxes and spaces were allotted for responses, and questions were made as concise as possible. Response categories were of standard form, the Likert scale being most common for attitudinal and perceptual questions. At the

end of the questionnaire there was space for additional comments. (See Appendix A for a copy of the questionnaire.)

No effort was made to be tricky, and none of the standard attitudinal items were included. This was not only preferred by the investigator, it was a prerequisite because of the high level of sophistication of Area Board members. Many of the prospective respondents are professional people, many of them being involved in social science research themselves. Many are psychologists or political scientists not likely to be able to respond without bias to scales well known to them. Furthermore, the board members in one or two regions had previously been asked to fill out a vast number of attitudinal responses for a project that was designed to develop and validate attitudinal scales. This left the members angry and unfriendly to such scales.

Data Collection and Preparation

Interviews with Area Board presidents were accomplished by a rotating team of three graduate level interviewers. All presidents responded in full, and all exhibited a cooperative attitude. Begun in late November of 1969, the interviews were completed in February of 1970. Notes taken during these lengthy interviews, some running to nearly two hours, were transcribed and typed verbatim after each interview. Copies were made and distributed to each interviewer. Then results were coded and indices of board accomplishments developed. (See Chapter Five and Appendix B.)

In conducting the interviews with board presidents, the presidents were consulted about the possibility of sending questionnaires to board members. We had considered the possibility of visiting each board and distributing copies, thus providing the opportunity for a direct appeal to members. But the idea contained a source of potential bias through the need to respond to questions about purpose going beyond the explanation in the cover letter, and might have made it difficult to insure a full distribution to absent members. So presidents were merely asked to mention the prospect of mail questionnaires in the future.

All but one board president agreed to let each board member make his own decision to respond or not respond on the basis of the cover letter and his own feelings. The other president felt that there were special circumstances covering his board, and felt that it should be a joint decision made in open session. The situation was a complicated one. The board in question was representative of a disadvantaged urban area, and was in the midst of an internal struggle and a struggle with the state. Members of the board had recently caused a reorganization of membership, and had also elected a new slate of officers. They were standing up to what they considered evasive tactics from the power structure in their effort to get funding for a comprehensive Community Mental Health Center. This board was predominantly made up of Black professional people who see their role in the community, as members of the Area Board, as a responsibility to reflect the true needs of their constituency. When members

of the project staff met with the board to discuss the possibility of being covered by the research of the Citizen Participation Project and the mail survey, they politely declined. They felt that it would be representative of a defeat in their efforts to increase the services in their area, and that money now allocated for research should be released for services. The investigators, respecting the wishes of the board, dropped them from the research plan, while promising to include them in the feedback from the research on the other boards.

Two waves of questionnaires were sent out to Area Board members. One wave included all persons on the Department of Mental Health records at the beginning of 1970, and the other wave went to non-respondents from the first wave, after a waiting period of approximately two months. Most of the first wave was mailed in January of 1970, but the records for two boards were not available until March because of organizational problems within the boards. Thus, the final mailings in the second wave could not be made until mid-May.

A total of 738 questionnaires were mailed out in the first wave, this number representing the actual registered membership total, less the 21 members of the non-participating board. Several boards were, at the time of the survey, slightly below their authorized size. Three hundred and ninety-one responses, 53 percent of those mailed, were returned on this wave. Another 96 were returned from the second wave, another 13 percent, bringing the total to 487, or 66 percent of the actual registered members. Of these, 47, or approximately 6 percent, were from members who had resigned, moved

out of the area, were hospitalized or otherwise unavailable, or who did not complete the questionnaire in a codable way. The final net sample is 440.

Coding of the questionnaires presented almost no difficulties. Most questions were closed-ended, and coding error would arise only from poor coding conventions. Thus, the coding was carefully monitored, and substantial check coding carried out. Few errors were found, and those were corrected. On a few of the open-ended questions, which were really fill-in of particular information, the problems that arose were those of omission or poor question construction. Several persons felt it necessary to omit the personal questions, especially the question of age (where there are consequently 30 blanks in the final data set). Poor question formulation was a factor mostly in the case of occupation. The word "occupation" is ambiguous in any case, but especially in the modern world where occupations are increasingly multi-disciplinary, and occupational responsibilities diffuse.

When the data were coded and put on computer tape for analysis on the IBM 7094, a comparison of means was conducted to identify possible differences between the responses in the first and second waves. A difference of means test was conducted on a large sample of questions, including all of those considered to be directly relevant to the analysis. Some were included from each section of the questionnaire. The differences that emerged were minute. The largest single difference was in ages, and the actual difference in mean age between the groups was less than two years.

Once the last of the questionnaires were coded and compared, a follow-up sample of 10 percent of the non-respondents was carried out by telephone. Thirty non-respondents were selected at random from a list of registered members not known to have responded, moved, or otherwise be eliminated. These persons were contacted, and asked a few simple questions to allow us to estimate the causes of non-response. Of those called, three had moved (10%), and one complained that he had written a letter to the investigators for further information and received no reply. (This situation is still unsolved.) This left 26 analyzable responses from the follow-up.

Out of the 26 follow-up respondents, four reported having resigned or "quit." Another five reported that their term had expired, and one said he "really didn't know if he were still a member." That left 16 (61.5% of the 26) who are still members.

There were no surprises among the 26 respondents who answered questions in the follow-up. The outstanding reason given for non-response was "being too busy." This was not a surprising response for a group who gave their occupations as: physician (2), Director of a Child Guidance Clinic, Hospital Administrator (2), lawyer (4), Coordinator of Self-Help Program, or minister or priest. In terms of opinion questions, 53 percent felt that their boards should make policy, and 31 percent felt that they should be advisory. Thirteen of the 26 felt that their experience on their boards had been "frustrating."

All in all, the differences between non-respondents and respondents seem to be small or hard to specify. They were less prone to see a policy role for their board, and probably more inclined to be frustrated. Thus, finding no evidence to support any other approach, we accept the explanation offered: that the non-respondents just felt they were too busy to respond.[1]

The Construction of Variables and Indices

Many of the variables employed in this study were taken directly from the responses to questions on the questionnaire. Others were constructed by separating out different responses to a single question, or combining separate questions into a single variable. A decision was made in all appropriate cases about the interpretation of non-responses and don't know responses, and the variable values treated as missing data when theoretically desirable. (The construction of variables is reported in greater detail in Appendix C.)

Analysis of Data

The form of analysis employed in this dissertation is the cross-tabulation method of the Harvard Data-Text system. It adheres to the characteristics described in basic textbooks on social science

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[1] It is true that a great many members who responded were also busy, but no further interpretation seems possible with existing information.

statistics.[1] Special attention has been placed on the gamma statistic described in Statistical Reasoning in Sociology.[2]

The Dependent Variables

The actual form of variables used in this research appears in Appendix C. However, the dominant importance of the dependent variables used in this research--the measures of members' evaluations of their boards--requires that a few additional comments be made in this chapter.

Because it has been the intention of this dissertation to capture the changing evaluations members make of their boards, we have chosen to construct a set of dependent measures which reflect changing perceptions of members. Each of the questions which form the basis for the measures of members' evaluations was asked twice in the questionnaire: once dealing with the "present," and once for the time at which members joined their board. Then an index of change was constructed for each dependent variable reflecting changes between the earlier report and the later.

Most of the evaluations held by members declined during their membership on their board. There were few cases indeed of evaluations becoming more favorable. Thus, our dependent variables have three categories: no change, some decrease, and much decrease. And,

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[1] Hubert M. Blalock, Jr., Social Statistics (New York: McGraw Hill, Inc., 1960).

[2] John M. Mueller et al., Statistical Reasoning in Sociology (Boston: Houghton Mifflin Co., 1970), pp. 279-294.

whenever these variables are used, the content of the response categories must be taken into account in the interpretation.

CHAPTER FOUR

ROLE THEORY AND AREA BOARD RULES

When men participate in the affairs of government, or in affairs in general, they do not do so randomly. They do so in the total context of individual needs and expectations, under legal constraints, and in light of the rules and expectations of society. They are free to evolve new methods of dealing with things, and to respond to situations with the latitude they can generate out of their own abilities. But in the end their activities fall into, or establish, patterns. In the long run, human activities are structured, and structures can be identified and studied.[1]

Social science is possible because of these regularities in behavior. Scholars have developed means of recognizing and discussing the regularities of behavior, the forces that shape them and the effects they have. This is true of individual behavior, and the behavior of institutions.

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[1]Robert K. Merton, "A Paradigm for the Study of the Sociology of Knowledge," The Language of Social Research, ed. Paul F. Lazarsfeld and Morris Rosenberg (Glencoe, Ill.: The Free Press, 1955), pp. 498-510.

One of the most interesting methods scholars have developed for dealing with patterns of behavior is the concept of role. The word "role," drawn probably, but not demonstrably, from the use of the term in dramatics, is ambiguous in general usage. It reflects the observer's belief that there are recognizable regularities attached to identifiable social positions, and that these regularities have importance beyond each special case. It evokes the idea of different actors playing the same part at different times with the same overall effect. These actors carry out the same set of actions, and use the same basic words, hoping to convey a prepared impression to the audience.

Social scientists have made substantial use of this concept in various fields of their art. Some have used it to describe aspects of the entire culture of various civilizations, and others have used it extensively in the analysis of society. Still others have adapted it to the analysis of individuals in clinical situations.

The wide currency of this term in social science suggests a primary utility. But its nebulous nature requires that it be carefully defined before it is employed. Undefined it can provide an illusion of elegance that is unwarranted by the information it summarizes. Thus, since the concept is of basic importance for this research, we will undertake to define the term fully, and to make clear the use of the term we have in mind.

We follow with a theoretical discussion of the term and its definition, with a presentation of the data that make it relevant to the Area Boards of Massachusetts Mental Health and Retardation.

Theoretical Definitions of the Concept of Role

The frequency with which the concept of role is used in social science means that there are a great many different definitions of the term. It is defined and redefined in relation to the particular problem at hand, and takes specific form as some function of the needs of the scholar conducting the exercise. But it seems that most of these definitions had stemmed originally, directly or indirectly, from a single source. According to the authors of Explorations in Role Analysis,[1] most of the prominent theoreticians express their indebtedness to Linton for his theoretical development in The Study of Man or in The Cultural Background of Personality.[2] Thus, it is not surprising that each of the major definitions has elements in common.

The authors of Explorations in Role Analysis, in a chapter devoted to the "definitional problem" describe these common elements with the following sentence: Individuals "(1) in social locations (2) behave (3) with reference to expectations."[3] By this they mean that roles are concerned with people in identifiable positions or generalizable functions, and that they carry out activities in these positions according to some composite of the expectations they hold

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[1] Gross et al., op. cit., p. 17.

[2] Ralph Linton, The Study of Man (New York: D. Appleton-Century Co., 1936); Ralph Linton, The Cultural Background of Personality (New York: D. Appleton-Century Co., 1945).

[3] Gross, et al., op. cit.

for themselves, or that they feel others hold for them as holders of the position.

These common elements assist in eliminating from consideration many things that are not considered by major role analysts to be part of the definition of role. However, they do not provide enough information for the researcher to proceed to the operationalization of roles for analysis. So, the authors of Explorations in Role Analysis went further to categorize the definitions of the major role theorists into three types. These are summarized briefly as follows:

Normative Culture Patterns:

The position most directly associated with Linton is that of normative culture patterns. These are ideal patterns which are considered behavioral standards which control reciprocal behavior. That is, they are an ideal pattern of behavior that sets the standard for the behavior of individuals. Deviations from this ideal pattern are considered exactly that--deviation. Only the ideal is considered as role. They define the proper behavior of persons of each identifiable status. Statuses are, in turn, defined as a collection of rights and duties. So, statuses are the static form of roles, and roles are the dynamic form of status. That is, statuses are collections of rights and duties, and roles are the proper conduct of these statuses by individuals. In this view it is the expectations of society that define the proper conduct of statuses and, hence, of roles. It is the totality of attitudes, values and behaviors ascribed by society that ultimately define the concept of role.

The choice of this particular definition of role depends upon the use intended for the term. It suggests a form of analysis directed at the larger aggregates of society, from the point of view of the sociologist or the anthropologist. A scholar more interested in the individual aspects of behavior would be more inclined to choose a definition more like that which follows.

Situationally Appropriate Patterns:

From the situationally appropriate patterns point of view there are three separate and equally important components of a role. One of these is the normative cultural aspect described above, and the others involve the individual's definitions of the total situations surrounding the role in question. As Stansfeld Sargent puts it, "a person's role is a pattern or type of social behavior which seems situationally appropriate to him in terms of the demands and expectations of those in his group."[1] Each person, therefore, defines the role for himself out of the total context of expectations and realities before him. He is subject to the pressures of the norms of the society, and of his reference group in particular, as well as his own expectations and interpretations of the way things are. But the focus is no longer on the cultural ideal and is now spread among several different aspects of role. Where the definition of role was entirely a cultural phenomenon in the normative culture patterns approach, it is now concerned with the individual actor and the immediate circumstances of his environment.

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[1] Ibid., p. 13.

Approaching the definition of role from this vantage point increases the utility of the concept for empirical research. It makes it possible to identify more immediately relevant groups for the measurement of roles, and adds dimensions to subsequent analysis.

Actual Behavior Patterns:

The third method of defining role differs in kind from the two previous cases. The earlier definitions were concerned with the normative aspects of behavior, with the creation of ideal models of behavior from some combination of social expectations. They described generalized standards that could be determined for individual actors to meet in their behavior. They assumed the existence of norms. In this third approach the normative aspect of role definition is eliminated from consideration. It concentrates on actual behavior of individuals in social positions. The ideal is of lesser importance, and the actual takes precedence.

The approach of those who define roles in terms of actual behavior begins with the identification of social positions and looks at the activities and relationships of the participants in these activities. They identify patterns of behavior out of real activities, and use these patterns to describe roles. But they are completely different from the previous approaches in their thrust. They are interested in categorizing behavior to allow for generalizations of the effects on others, or on the individual, of repetitive behavior. But they are no longer able to discuss the effect of social expectations through the concept of role. They in effect exchange the power of

this kind of analysis for the advantages of starting from the concrete and moving to the abstract.

There are a great many definitions of role in the literature of social science, and they are generally covered in the three types above. But these three types leave one problem, of special interest for the research at hand, unmentioned. That is the problem of roles for institutions. Institutions, Area Boards in our analysis, are made up of individuals. They have rights and duties, statuses in the terminology of the definitions above, and they try to carry out their rights and duties. Thus they can be said to have roles in the formal sense. And it will be these roles especially that will be of greatest interest for the remainder of this report. However, since institutions are made up of individuals and deal entirely with individuals in other institutions, it will be the attitudes and perceptions of individuals that will be of primary importance.

In choosing between the types of definitions listed above, it is important to remember the needs of this research. We are interested in a small and relatively ambiguous sub-system of the social structure. There is only limited agreement on the rights and duties of elements of this sub-system, and therefore it would initially seem unrealistic to discuss the role of the boards in the terms of the normative cultural patterns definition. There is little cultural consensus on their role, and the cultural definition does not easily apply in the absence of an established norm. Furthermore, it is precisely the differing expectations of groups in the society that is

at the core of our interest, and the uniformity implicit in the cultural definition would reduce the effectiveness of that model.

The third definition, called the actual behavior pattern, would also fail to meet our needs. It cannot be stretched to include the idea of proper role which is of such great importance here. It is exactly in the conflict between actual and expected role that the Area Board members experience their greatest difficulty. Thus, we will pay little attention to this definition of role.

That leaves the second definition, the so-called situationally appropriate patterns, which does fit the needs here. It allows for conflicting ideas on the role of the board, and allows the ambiguous nature of the system to be taken into account.

The theoretical review here is deliberately brief because the concept of role is most appropriately defined specifically. It must be carefully operationalized if it is to have meaning. So we go now to the problems of operationalizing the concept as we have decided to define it.

Defining the Role of Area Boards

The purpose of the theoretical discussion in the preceding section was to introduce the reader to the overall characteristics of role analysis that set the stage for the more refined definition of the role of Area Boards in the mental health and retardation system of Massachusetts. The purpose of this section is to formulate a more specific definition of the Area Board role, and to make it relevant to the research at hand.

The important perspective throughout this research is the opinions, perceptions, and behavior of Area Board members. It is the individual members whose actions will finally determine the success or failure of the Area Board form of citizen participation, and consequently their perception of the role of the board that is significant. We are interested, then, in their formulation of the role of the boards, and the forces that shape their impressions. Other renditions of role will be considered in the appropriate place, since members are sensitive to the environment of expectations around them; but it is only in their understanding of this environment that we can make any progress toward our goal.

The Area Board members of the Massachusetts mental health and retardation system are sworn members of the system. They take an oath to carry out responsibilities as defined by law. But the law does not fully define their role, or at least not in a fashion that is clear and compelling, and the members must fall back on interpretations and understandings that derive from other sources. Thus, the definition of the role of boards that we will consider here is complex and fragmented. It is hard to define and variable. What follows below is a discussion of the range of considerations that go into a workable definition of the Area Board role.

Any political system depends in the first instance on its ability to establish some form of legitimacy for its activities and authority. This may be only the legitimacy of force, or it may be the more acceptable legitimacy of the social contract. But every

existing system must develop some form of it. So, also, for specific sub-systems within governmental systems. They usually share in the legitimacy of the larger government, but they may also develop forms of their own.

The mental health and retardation system in Massachusetts is no exception to the rule. It is not a major political sub-system, but it is an agency of government established for the purpose of providing a specified set of services to the public. As a state service agency it draws its authority first from the legislature of Massachusetts. That body is responsible for its creation and maintenance. It established the agency, and it provided the basic guidelines for its operation. Much of the specific authority to set policy and organize services was delegated to the head of the agency, but the legislature maintains its authority to overrule the agency and has continuing control of its budgetary appropriation.

Within the mental health and retardation system in Massachusetts, the ultimate authority of the legislature is not questioned. Some of its actions are questioned, and some are considered unfortunate by local observers. But the basic right of the legislature is not questioned. It has a legitimate authority. Similarly, some of the actions of the delegated agency are sometimes questioned, and sometimes considered unfortunate. But, as in the case of the legislature, its basic authority is not questioned.

Area Boards are a creation of the legislature, as expressed in law, and under the immediate jurisdiction of the Department of

Mental Health. They have a legally defined status, and the members have formally accepted their position in the system. However, it is also the case that the same principles and beliefs that lead Area Board members to accept the legitimacy of the government, and of the sub-system in which they are taking part, lead them to invoke a competing legitimacy for the boards. American citizens are raised with the basic tenets of government theory and practice that are taught in their homes and in their schools, and they formulate ideas about the proper conduct of government. These are modified by experience throughout their lives, but they always maintain a viewpoint on the operation of government. Among these ideas and viewpoints they develop a concept of the proper role of the citizen as a participant in government. These ideas may differ drastically from individual to individual, and even from time to time, but the citizen is never without them.[1]

The citizen's perceptions of the proper role of citizens in a democratic society has a complicated and not entirely understood origin, an origin which will not be dealt with in any detail here. It is a perception that leads the citizen to act in certain ways under certain circumstances. The perceptions of Area Board members will be presented below; so for now we only reference the fact that there is a citizen perception of the role of citizens in a democratic system, that it is another aspect of the process of legitimization, and that

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[1]There are many sources on political socialization. See, for example: Fred I. Greenstein, Children and Politics (New Haven, Conn.: Yale University Press, 1965).

it may at times conflict with the legitimizing authority of the established system.

Continuing with the development of the research definition of the Area Board role from the perspective of the citizen member, we return for a moment to a theoretical definition presented in an earlier section of this chapter: the situationally appropriate patterns definition. The reader will remember that there were three different elements important in this definition. Two of these involved expectations, one of these being the expectations of the individual actor, and one being the expectations of other relevant actors in the system as perceived by the actor. The other element was the normative orientation of the definition: the idea that there is a 'proper' role to be carried out in practice. We will now try to delineate the research definition of Area Board role in terms of these three basic elements.

The individual expectations of Area Board members are limited here to the case of expectations that the citizen member holds as part of his perception of the proper role of the boards. We artificially distinguish between the impact of legal definitions of role and the expectations of others, to demonstrate the importance of citizen perceptions of the role of Area Boards which become an important part of the total complex of normative models incumbent upon members.

In making the definition of citizen expectations distinct from the larger context of expectations we are involved with the difference between normative expectations and actual role behavior. It

was decided that it would be important to know both how the board saw the role in practice, and what they felt the 'proper' role of the board should be. Thus, for every question considered part of the definition of board role there are two answers: one for actual role and one for 'proper' role.

The selection of particular questions to define the role of the boards was made in the light of initial interviewing of board members, additional interviews with persons knowledgeable about the mental health and retardation system, a reading of the handbook, Your Area Board, distributed to board members by the Department of Mental Health, and more general knowledge of the imputed role of other citizen boards. Information was solicited to identify the dimensions of role that could be used in the research. Particular topics were sought to cover the options in terms of role possibilities that could reasonably occur to citizen members of boards. That is, we sought not only the direct and most obvious aspects of role that were spelled out by the law, but all of the possibilities that could seem reasonable to citizens with their differing perceptions of the proper role of the board in the wider mental health and retardation system. Some of these options have their source in the roles assigned to other citizen bodies in other systems. Others, which were also employed in this research, are particular to the specific mental health and retardation system of Massachusetts.

Before we describe the specific questions that were used to define the role of the boards in this research, it is useful to make

note of one further criterion used in their selection. Each one of them describes, individually, a possible behavior of Area Boards. That is, they refer not to abstract goals and theoretical concepts, but to realistic, operational alternatives. They went, in the survey instrument used in this research, under the general label of "purposes and practices" of Area Boards, but they represent serious options.

Under the heading of 'purposes," above, there were five areas of interest covered. These included the basic three general functions which seemed to cover the nature of citizen board activities: advice to the parent agency; decision-making authority in the realm of policy; and, the oversight of the delivery of services. They also included an information question on one of the basic specific functions ascribed to the boards by the Department of Mental Health: to increase public support for efforts to provide better mental health and retardation services in the board's catchment area. Then they include, as a check on more controversial issues, a question on the purpose of the board to learn and represent the views of area citizens on issues relating to mental health and retardation services.

In addition to these questions on the purposes of the boards, four questions were asked concerning board practices. These were intended to supplement the questions on purposes by repeating the same general information in a concrete case. These questions concern Area Board practices in the realm of public education programs, planning and initiation of new services, review of area plans, and allocation of funds within catchment areas.

For each of the nine questions outlined above, citizens were given three options for response. They could agree that it was a purpose of practice of their board, that it was not a purpose of practice of their board, or indicate their uncertainty as to the answer.

Each of these response ranges was available for "what is," and "what should be." The handling of the uncertain responses is described below in this chapter, as is the individual differences between what the citizen saw as the ideal and the reality. First we will review the meaning of the questions in greater detail.

For the sake of simplicity, they will be discussed in the order in which they were presented above.

(1) The Advisory Role of Area Boards:

One of the traditionally honored functions of citizen boards in governmental service agencies and programs is that of giving advice to the parent agency or program. An old tradition, it is in the process of being further developed and applied as a result of the increased demands of private participants in the country to have a say in the way the government conducts its activities. As was discussed above, it was suddenly discovered in the 1950's and the 1960's that the substantial increase in the number and variety of services offered to the public increased drastically the level and nature of organized public reaction to the government. This became most evident in the public outcry that resulted from federal efforts in the area of urban renewal. Citizens who were being moved or relocated from

their homes to permit rebuilding inspired a protest movement that disturbed the public officials responsible for policy, and disrupted the actual operation of the program. Efforts were made to accommodate the level of opposition, and the vehicle for this was to establish advisory panels of citizens to consult with government officials and advise them in advance of the needs of the citizens affected. They were conceived as liaison groups between government and the public. The opinions of these citizen groups were merely advisory, but they were held by many to be an important form of participation in government, or at least a means of disarming public outcry.

In the case of Area Boards, the advisory function can take many forms. We will see examples of these forms in another section below, but it is useful to point out one limitation of this function by any conception. Area Boards are entities that belong to the area level of government. As such, they hold jurisdiction in an area that contains numerous community facilities, and often state hospitals. They are one of approximately five areas in each region, and one of thirty-seven in all. Their advisory function is limited primarily to the elements of the state system that relate to the areawide system. They have contact with the representatives of local facilities as sponsored by the state government, and to the regional offices of the Department of Mental Health. Finally, they have a direct connection, the most direct of all their connections, to the area director of their area (or the surrogate for the area director). What access they have to the state officials of the Department of Mental Health, or to the

Governor, are informal. As an advisory body they are expected to advise through their area director, their regional administrator, or directly to local facility heads.

(2) The Policy-Making Role of Area Boards:

The tradition of citizen boards empowered to make policy for governmental agencies is similarly well established. It is more frequent at the higher levels of state government than at the regional or area level, but it is not unknown in almost every context. The purpose is much the same as it is in advisory groups, except that it usually resulted from a definite effort on the behalf of influential citizens to establish a formal control over the operations of government. Governmental agencies often accepted it willingly with the idea that a citizen board or influential citizens could act as a buffer against public criticism, and form the nucleus of a protective interest group. Public school boards serve as an example. These boards may be legal entities with the power to effectively control the school system, but they also serve to legitimize the activities of the school system.

The policy-making function of citizen boards may take many forms. It may be hardly distinguishable from advisory bodies in its everyday operation, or it may, in some cases, maintain an authority more like that of the administrative arm of the service or agency than anything else.

(3) The Oversight Role of Area Boards:

Oversight is a technical term which refers to the 'censor' function of boards. It means that the board has the duty and

authority to watch over the activities of the provision of services and raise the alarm if conditions should warrant it. The origin of this function is obscure, but it is a well-established practice in American government. Such activities are best described by the term "watchdog agencies," often applied to federal regulatory bodies. When boards perform this function it is called oversight, and it does not necessarily imply the range of legal powers associated with the federal regulatory agencies. However, the kinship of the two is clear. Both serve to keep themselves informed of the activities in their domain of interest, and take appropriate actions when advisable.

In the case of Area Boards this function is operational due to the position of the boards in the state organizational structure, and because the members of the board have a ready audience for reports of misdeeds in the form of the public media. The news nedia are ready to publicize information transmitted by these legitimate entities.

(4) Increasing Public Support for Better Services:

No agency of government is able to expand its activities indefinitely at will. It must rely on legislative authority and appropriations. But most agencies are eager to expand their services, and they make use of available means to seek increased support for the expansions they envison. Public boards, with a claim of expertise in the area of services, can make a more disinterested appearing case

for the increase of services by the agency. They are in the position of not profiting directly from any increase, but of knowing the needs.

Area Boards can act in this capacity by preparing materials to convince the public of the need, and by organizing a lobby to the legislature. They can, in other words, become a public relations arm of the Department of Mental Health.

(5) Learn and Represent the Views of Area Citizens:

It has become a commonplace of contemporary citizen participation to talk about being representative of a public constituency. This harkens back to the recent history of the movement, especially that part tied to the poverty efforts of the federal government. The clients of the poverty programs were deemed to have been deprived, by social processes, of their due representation in government. They were unable to make their needs as a special minority known and attended by existing machinery. Thus it became a matter of legal intent to provide the poor with as much representation as possible in the activities of the poverty program.

Area Boards were designed by the legislature to be representative of their constituencies.[1] But the special nature of the fields of mental health and mental retardation raises immediate questions. A substantial portion of the services of the Department of Mental Health are directed to the hospitalized mentally ill and the retarded who are sufficiently deficient to require specialized care.

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[1]Demone, op. cit., p. 7.

Both groups would seem to be inappropriate for membership on citizen boards.

In actual practice it is not difficult to locate and recruit recovered mental patients who would be easily able to serve as citizen participants. Such patients are often highly capable and lend an important element of knowledge to the process of Area Board business.[1] But, for the most part, the problem of representation by consumers of services is handled by appointing members of the families of the mentally ill or mentally retarded. And, in a very real sense, family members of clients of the system are consumers of the services.

There are several ways in which boards can be made representative of their constituency. One of these is to make sure in the selection of members that they reflect the geographic, economic, or educational distribution of characteristics in their area. Another is to encourage members to take the diversity of needs and opinions of their constituency into account in their activities. The difference is that of making the board a microcosm of the constituency and expecting members to serve as representatives of the constituency rather than as representatives from the constituency.

In the case of Area Boards the geographic distribution is required by law, and what is of interest is the extent to which members feel compelled to reflect the constituent view in their activities.

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[1]Several of the Massachusetts Area Boards have recruited such members and report great benefits.

(6) Sponsor Programs to Educate the Public:

This function can be taken as a specific example of Number (1) above, and need not be further elaborated here.

(7) Plan and Initiate New Services:

The responsibility of Area Boards to plan and initiate new services is not one that can be considered a standard function of citizen boards and, as such, it is considered in this research as a function specific to Area Boards. It is also a common activity of Area Boards, and will be treated substantively in another chapter. For our purposes here it is sufficient to refer to the fact that the boards have exerted a great deal of effort to establish new services that range from the creation of a community mental health center to the increased availability of counseling for school departments and police.

(8) Approve Area Plans:

Area plans are documents describing the annual activities of the Department of Mental Health in any given area over a given year. They are in the form of an annotated annual budget, and represent the primary working plan for all the services in the area.

(9) Allocate Funds within the Area:

Under the existing legal structure this is a function carried out in its direct form only by the employees of the Department of Mental Health. But, since the boards have the responsibility to approve area plans, which include the budgets, there is potential for the actual allocation of funds.

These nine topics, then, fully define the role of the boards that will be of interest in this research. However, in the interest of simplicity, we have chosen to concentrate, in many cases, on the three that are most descriptive of the role of the boards, while also being of primary interest to the citizen members of boards. Information will be presented where it is deemed to be useful on all of these nine questions, but the three of predominant concern will be the functions of advice, oversight of services, and policy-making.

Looking at the three functions being used as the bulwark of the interpretation of the role of the boards, it appears that there is a kind of natural order among them, a continuum of power and authority. It would seem, on an intuitive basis, that the lowest in terms of power and authority would be the advisory function. Next would be the oversight function, followed by policy-making. They form, in this way, a logical order. This idea of ordering was not tested through any statistical procedure, but it has face validity, and is borne out by the patterns of responses to relevant questions throughout the survey. Since heavy reliance is not placed on this characteristic of the data, it need not be rigorously developed.

CHAPTER FIVE

THE ACHIEVEMENT OF AREA BOARDS AND MEMBERS' EVALUATIONS

The primary purpose of this dissertation is to investigate the relationship between the various aspects of the Area Board role and the evaluations members of the boards make of the usefulness and workability of the boards. We want to be able to pinpoint the criteria Area Board members use in evaluating their boards and to place it in the larger context of criteria for evaluation of citizen participation as developed in Chapter One. We will be testing several hypotheses which have been derived jointly from empirical examination of Massachussetts Area Boards and from theoretical orientations of social science.

The first hypothesis, to be tested in this chapter, is that it is the successful fulfillment of the goal-oriented aspects of Area Board role, specifically board achievements and accomplishments, which influence members to a good evaluation of the boards. That is, that board members' positive evaluations of their boards are a product of the successful pursuit of the boards' purpose to achieve results and accomplish tasks.

The empirical source for this hypothesis, previously referenced in Chapter One, is the preliminary discussions this investigator held with Massachusetts Area Board members in the first phase of this research effort. A number of board members described in detail the frustration of working on boards which did not do "very much" or "anything." They felt that some of the feeling of dissatisfaction with their boards, or with boards in general, might be due to their lack of accomplishment--due, that is, to their failure to carry out the basic goals of boards to accomplish things.

The theoretical source for this hypothesis, also mentioned in Chapter One, is the sociological research of Caplow. Caplow has asserted, in his Principles of Organization, that the failure of accomplishment is a cause of negative evaluations of organizations--or, conversely, that high evaluations are positively correlated with achievements.[1]

The first and most obvious approach to the accomplishment role of the Area Boards is to consider the various specific achievements and accomplishments of the Massachusetts Area Boards objectively and independently measured. Then these achievements and accomplishments could be systematically described in summary, quantitative fashion, and tested. This has been done below.

Secondly, we must also distinguish the impact upon members of a perception of successful fulfillment of the accomplishment role of the boards from individual members' importance in that fulfillment.

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[1]Caplow, op. cit., p. 123.

It may well be the case that it is the individual member's perception of having made a personal contribution to his board's accomplishments which makes the difference in members' evaluations.

The test of the achievement role hypothesis will be divided into two parts, reflecting the two different ways in which the success or failure of the achievement role of the boards might influence the board members. The first, the independently determined measure of achievement and accomplishment, was obtained from data collected from the presidents and vice-presidents of the Area Boards. The statistical preparation of these data was described in Chapter Three and in Appendix C. These data have the virtue, elsewhere cited, of being based on records (minutes) of Area Boards as well as impressions and memories.

The second approach to the data also comes from the survey of members, and is detailed, as is the previous one. It consists of the number of projects initiated or launched by individual members.

The Accomplishments and Activities of Area Boards

In an enterprise as complex and diversified as that of an Area Board in the mental health and mental retardation system of Massachusetts, and with each of thirty-seven boards using their best imagination to involve themselves thoroughly in their jobs, there is bound to be a very large number of activities practiced. Formal descriptions of the duties and responsibilities, as in Your Area Board,

often go on for pages without proceeding beyond the most general descriptions. Any efficient and valid measure of the accomplishments and activities of Area Boards must include a large number of variables.

From the myriad of questions asked of Area Board presidents and vice-presidents about their Boards, twenty-five variables were prepared. The criteria mentioned previously were that the variables should reflect activity creating new mental health or retardation services or facilities, improving the quality or increasing the quantity of mental health or retardation services or facilities, substantially increasing public awareness of the need for such services, or having a high probability of doing one of the preceding things. Of the twenty-five variables, some are repeated more than once in different forms. Therefore, since these variables are the basis of the factors and indices used in this part of the analysis, they will be listed below. Following this list some of the variables will be discussed in greater detail. These latter variables are those considered to be of special importance as indicators with intuitive validity. One further distinction must be made before the list is given. We must try to clear up a possible source of confusion about the verbal descriptions used for the aggregate of the variables used here, and for the factors and indices derived from these variables.

The concept we have been referring to as accomplishment, activity, or even achievement is specific as we have operationalized it, but it is not precise according to its normal usage. Citizens

trying to explain their frustrations with their Area Boards often declared that "My board hasn't done anything"; or, perhaps, "My board has accomplished nothing." These statements are idiomatic statements expressing a broad feeling of inactivity and lack of success.

When members were pushed for further precision, they would usually resort to examples, and the examples are included in the variables selected. But, in general, the concept being used here is more than merely activities, accomplishments, or achievements; it is all three of these things. More limited usages will be employed, but will be readily recognizable from the context.

The variables included in the analysis of accomplishments of Area Boards are:[1]

1. Total number of services assisted
2. Total number of services, weighted by importance
3. Total number of services, weighted by stage of development
4. Total number of services, weighted by importance and stage of development
5. Average degree of involvement of board
6. Average involvement, weighted
7. Total number of contacts
8. Total number of contacts, weighted
9. Money raised within area (local sources)
10. Money raised from state sources
11. Money raised from the federal government
12. Concerted political effort
13. One-shot political effort
14. Contact with the legislature
15. Contact with the Department of Mental Health
16. Contact with the Commissioner of Mental Health
17. Contact with the Governor
18. Contact with the Administration and Finance Department

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[1]For information about weighting of variables in this list, see Appendix B.

19. Dealings with the federal government
20. Area board acts on annual plan
21. Area board compiled budget
22. Area board reviewed institutional budget(s)
23. Number of agencies donating money or goods
24. Area board hired (has) full-time help
25. Area board has privately incorporated

The reader will notice that the first four variables on the list are concerned directly with the provision of services. This category includes all of the basic elements of mental health and mental retardation service, from traditional institutions to more contemporary community programs. These services will be the first explored in greater detail because they are the most prominent activities that fall to the jurisdiction. They are, after all, "what it's all about." Everything else in the entire mental health and mental retardation system is, or should be, directed toward the provision of services--services of every type, but services nonetheless.

There is an almost endless variety of possible kinds of services which could be planned or implemented by Area Boards. The multiplication of kinds of services is, indeed, a by-product of the community mental health effort. So there were a great many possible services which could have been reported by the Area Boards, and there were actually twenty-five different types which showed up.

Not all of the twenty-five kinds of services need be presented here. Many of them appear only once and are taken into account only in the totals. The important services are listed below in Table 1. Most of these services are self explanatory. Public Forms refer to cases where the Area Board has called a public meeting to

TABLE 1

NUMBER OF BOARDS THAT HAVE ESTABLISHED OR PLAN TO ESTABLISH SERVICES

Type of Service	Number of Boards[a] Planning the Service[b]	Number of Boards[a] That Have Established the Service[b]	Number of Boards[a] Involved in Planning or Establishing the Service[b]
Written Survey of Needs-Resources	2	13	15
Adult Out-Patient Clinic	0	11	11
Consultation for Teachers, Clergy, etc.	0	11	11
Nursery for Mentally Retarded	10	1	11
In-Patient Facility	3	7	10
Public Forums	0	9	9
Program for Drug Addicts	6	3	9
Community Mental Health Center--Meets Five-Fold Federal Requirements	7	1	8
Children's Out-Patient Clinic	0	7	7
Half-Way Houses	4	3	7
Day-Care Centers or Classes for Retarded	4	1	5

[a]Number refers to boards, not services.

[b]Figures do not include services that existed prior to Area Boards or for which Area Boards had no responsibility.

solicit interest or guidance on mental health or mental retardation issues. The references to "Five-Fold Federal Requirements" means that these are full-scale community mental health centers meeting the requirements spelled out in federal regulations for emergency, in-patient, out-patient, day-care and community consultation and education services.

Across the top of Table 1 there is a differentiation of the nature of the Area Board participation in the development of the services mentioned. These differences represent the different kinds of effort which boards put into the development of the services on the left side of the Table. The distinctions are important because they represent different kinds of activities, and, most likely, different levels of personal satisfaction for Area Board members. These differences, as well as differences due to the amount of energy each board put into the record of participation presented in Table 1, are taken into account in the weighting schema (presented elsewhere). For now let it be sufficient to report that the amount of contribution each board made to each service varied considerably. Some boards can assume the entire responsibility for a new service, having conceived the idea and carried it through to its completion. Other boards were little more than a "rubber stamp" for actions carried out entirely by others--e.g., by Department of Mental Health staff or by the private associations for mental health or retardation.

Continuing on down the list of variables reflecting accomplishments, there are two variables which refer to the contacts the

Area Boards have made with other service institutions in the community. This is another important activity of Area Boards. The Area Boards are specifically charged, in the handbook, Your Area Board, with the coordination of services and activities relating to mental health and mental retardation, and the boards have tried to carry out this responsibility. Table 2 below outlines the contacts that the Area Boards have made with the service institutions listed. It also describes the nature of that contact. There have been a number of instances of collaboration on activities, and those collaborations are included in this Table. Coordination, then, has been an important part of the activities of Area Boards.

There is one omission from the Table that would be of interest. It would seem appropriate for Area Boards to have extensive contacts to assist one another with their problems of role definition, and to gain strength from association for more powerful political actions. However, the amount of contact at the time of the interviews was minimal. No two boards were in regular or formal contact, and joint meetings were never practiced. Since the time of the interviews this has begun to change. Several boards have taken strenuous action to encourage their regional administrator to call a regional assembly of selected board members. And others are now arranging a statewide meeting of Area Boards--a kind of workshop for board members.

Next on the list is a set of variables dealing with money raised by the Area Boards. These are important variables, but

TABLE 2

NUMBER OF BOARD CONTACTING SERVICE INSTITUTIONS

Institutions	Total Number of Boards Having Contact	Some Selected Kinds of Contact[b]		
		Overlapping[c] Membership	Cooperation on a Project	Meetings for Discussion of Special Problems
Churches	37	36	21	4
Schools	36	33	16	7
Local Association for Retarded Children	36	34	21	3
Local Mental Health Association	34[a]	34	21	3
General Hospitals	29	19	19	6
Law Enforcement Agencies	23	18	3	10
Labor Unions	23	22	1	5
Anti-Poverty Agencies	17	13	7	4
State Hospitals and Clinics	15	7	9	2
Clinics	13	2	3	3
Universities	11	8	5	5

[a]Three boards do not have Mental Health Associations within their areas.

[b]Other kinds of contact have been: regularly meeting "coordinating councils" and a committee or person specifically responsible for contact (as a hospital committee). These are included in the figures in the first column.

[c]Overlapping membership is dual membership on board and in contact group.

controversial. Not all boards have tried to raise money, despite its obvious importance in the provision of mental health and mental retardation services. There are good reasons for the different approaches to the question of raising money. Before we enter into a brief review of the financial records, some of the complicating factors should be pointed out.

First and foremost among these factors is the fact that few people are certain in their own minds concerning the legal authority of the boards to handle money. Under ordinary circumstances a board could be expected to receive money from gifts and bequests, from assessments made against cities, from federal grants, and otherwise. However, the law is not clear on the fiscal powers of the boards. In Chapter 735, the law reads that an Area Board may "receive and administer any gift or bequest of personal property or funds in trust ..." and "receive funds under contracts or other agreements from community sources ..."[1] These phrases are subject to conflicting interpretations. There are those who take them to mean that the boards can receive money from recognized sources and disburse it according to the intentions of the donor. Others, however, feel that this cannot be done, and that any money received must be returned to the "general fund" of the Commonwealth and used according to the distribution made by the legislature.

Area Boards have found different ways to deal with this problem, and the Department of Mental Health has offered the opinion that

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[1] Massachusetts Department of Mental Health, Your Area Board, op. cit., p. 33.

Area Boards can disburse funds if they are put through (hopelessly cumbersome) trust funds in banks. But each of the solutions is complicated and indirect (Area Boards are incorporating privately as non-profit groups to provide mental health and retardation services) and many boards have avoided the matter as too stressful or too aggressive.

Despite the complications, twenty Area Boards have raised money. The amounts raised range from tiny amounts to hundreds of thousands of dollars. Most of this money is from private sources, or from the Commonwealth of Massachusetts. Three boards have received large grants from the federal government. But whatever the source, Area Boards are proud of their success in raising money, and this success is considered a substantial accomplishment. A brief summary of their success, source by source, is presented in Table 3 below.

TABLE 3

AREA BOARDS RAISING MONEY
(BY SOURCES)

Sources of Income	Some Money Raised N	%
Gifts and bequests	13	35
Money raised through functions	5	12
State money	11	30
Federal money	4	11
Money in trust	2	5
Other money	16	43

Another set of variables on the list is concerned with political activities of various types. Boards have entered into all kinds of political actions, from quiet lobbying with members of the Department of Mental Health to the conduct of a "sit-in" in the Office of the Governor of the Commonwealth. Some boards engage in more of this kind of activity than others, and with differential success rates, but all boards have made some attempts at "politiking."

The most prominent form of political action undertaken by Area Boards, either by the boards as a whole or by involved members individually, was contacting members of the state legislature. Boards usually contact the representatives of their own catchment areas, although many have friendly relations with other legislators and use them. In all, thirty-two boards out of thirty-seven reported contacting legislators, and others have done so since the time of the interviews.

Next to legislative contacts, contacts with the Commissioner were most common. Nineteen boards have done so. Eighteen boards have contacted other high-ranking members of the Department of Mental Health. Four of the boards have contacted the Office of Administration and Finance, the fiscal arm of the government, which is directly under the Governor, and two have gone straight to the Governor.

With the advent of the catchment area system, and the regional system, implemented as part of the reorganization of the Department of Mental Health in 1967, each area has been asked to develop an annual area plan. This plan, an outline of all the definable

mental health and mental retardation needs and services in an area and a plan for changes in services, is the basic document of a catchment area. It is supposed that this document, approved (according to law) by the Area Board, and then by the Commissioner, will be the foundation of all mental health and mental retardation activities for an entire year.

In actual practice, the area plans have not been as complete a success as hoped. Preparation of area plans has been a matter of individual responsibility, and many areas have not exercised that responsibility. Thus the preparation, or at least the review, of area plans by Area Boards has been spotty. Some have not seen area plans because there have been no area plans, and others have seen the plan only at the last minute.

The survey of Area Board presidents and vice-presidents showed that twenty-six boards were familiar with the requirement for an area plan, but that only eighteen could say for sure that there was an area plan in their area. Furthermore, at least ten of the boards saw the plan only on the night it was submitted to them for approval.

Because the area plans are expressly made subject to the approval of the Area Boards by law, and because they could be such an important part of the provision of services in any area, many Area Board members feel strongly that their boards should be involved in the preparation and approval of the plans. That they often do not has been a matter of discussion and anger, and must be taken into account in discussing activities or accomplishments of the Area Boards.

In the paragraphs above activities and accomplishments of Area Boards have been described in some detail. Some of the activities presented are rewarding only if they meet with some success; others are directly rewarding--e.g., the creation of a new service. But, however the results of this quick review are counted, it is clear that the overall record of the Area Boards does not indicate that boards have "done nothing." On the contrary, the boards have created or helped to create enough new services that the provision of new services alone should justify a great deal of effort.

Looking at the information on board accomplishments presented in the paragraphs above, it is hard to believe that this form of the hypothesis stands much chance of being supported. If the board members' criteria for positive evaluations of their boards is successful activity and achievement, there should be many enthusiastic members. We recognize the possibility that the frustrated members are clustered on a few boards which have done very little, and will test this possibility below. However, from the standpoint of an overall impression, the idea that members' evaluations depend upon successful implementation of the accomplishments role of the Area Boards does not look promising.

With the prospect that independent measures of successful implementation of the accomplishments role of the board are not going to produce confirmation of the hypothesis, we can look to the more individualistic form of the hypothesis: that individual contributions to accomplishment is the thing that influences members' evaluations.

The Individual Activities and Accomplishments of Board Members

Thus far we have spoken of the aggregate actions and accomplishments of Area Boards. Now we can discuss individuals' perceptions of their own activities and accomplishments within their boards. Our hypothesis tells us to expect that, while the members may feel a strong sense of achievement from the successes of their boards, they may have an even stronger sense of achievement for activities and accomplishments personally promoted. That is, while members' perceptions of successes of their boards as a unit may lead to positive evaluations, members' own feelings of having contributed to the results achieved by their boards may have an even greater effect on members' evaluations.

We have two sets of questions which identify the belief of individual members concerning their personal contributions in one very important part of Area Board accomplishment. One of these asks members if they "have ... recommended or tried to initiate any new mental health or retardation programs or activities ..." to be sponsored by their Area Board.[1] And it asks how many such programs or activities have been recommended or promoted. The other question asks if any of the above-mentioned programs or activities were "successfully launched, or /are/ expected to be launched ..."[2] It asks

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[1]See Appendix A for a copy of the questionnaire.

[2]Also see Appendix A.

if one or more were fully launched, if one or more were partially launched, or if none were launched in any way.

Responses to these questions show that fifty-three percent (N=419) of the members believe that they have initiated or promoted the initiation of new programs or activities. These programs or activities might be relatively small, as in the case of a newsletter to related services, or large, as a community mental health center. But it is reasonable to assume that a positive response to this question would result in some sense of pride, and that that sense of pride could result in a more favorable evaluation of Area Boards by the individuals concerned.

To carry this argument to a more stringent point, we can consider the further information available. Of the members who initiated new programs or activities, how many saw their efforts come to a fruitful conclusion? There was a total of 265 individual members who felt that they had initiated new programs or activities. Of these 265 members, forty-two percent had not yet seen any of their programs or activities partially or fully launched at the time of the questionnaire. Thirty-four percent had seen their efforts partially rewarded, and twenty-five percent had seen them fully rewarded.

From the evidence here it would seem that a fair number of members have had reason to be encouraged by their participation on their Area Boards. A surprising number of individuals have seen concrete results of their work, and we could expect this to be reflected in a more feasible evaluation of their boards.

Having reviewed the existing information on boards' activities and accomplishments, we can continue on to the main analysis of this chapter--the relationship of activities and accomplishments to members' evaluations.

Area Board Activities and Accomplishments and Members' Evaluations: An Analysis of the Independent Data

Detailed information on the preparation of the data for this segment of analysis is reported in Chapter Three above. Here the reader is reminded only that the information on each board was added to the individual data record of each of the members of each of the separate boards. That is, each board member's record includes the variables which describe the activities and accomplishments of his board (Political, Services, Contacts and Local Factors), as presented in the section of this chapter, "The Accomplishments and Activities of Area Boards." Therefore, cross comparison of members' perception and the performance of their board is possible.

The primary question of this analysis section is, "What is the relationship between board activities and accomplishments and the members' evaluations of their boards?" We want to know more specifically if, as many observers seem to believe, the decreasing evaluations of boards by members is a result of the failure of the boards "to do anything." And the answer is clear: the activities and accomplishments of the Area Boards, as measured by independent counting of these activities and accomplishments, are unrelated to members'

evaluations of the boards. There is no relationship between the activities and accomplishments and members' decreasing evaluations.

To make this complete lack of relationship clear, we have included in Table 4 below the gamma correlations produced by the cross-tabulations of activities and accomplishments data and our three measures of member evaluation. The reader will note the uniform lack

TABLE 4

THE RELATIONSHIP OF INDEPENDENT ASSESSMENTS OF BOARD ACTIVITIES AND ACCOMPLISHMENTS TO MEMBERS' EVALUATIONS OF AREA BOARDS

	Members' Changing Evaluations	
Board Activities and Accomplishments	Area boards are a useful addition to the MH & MR system	The area board form of citizen participation will work
Political Factor	-.08	.12
Service Factor	.12	-.12
Contacts Factor	-.10	.18
Local Factor	-.02	.13
Overall Index (Shortform)[a] (3 categories)	.01	.08
Overall Index (Long form)[a] (3 categories)	-.03	-.02

[a]See Appendix B for an explanation of these forms.

of even the most tenuous relationships. Furthermore, all of the significance tests on these data are not significant, showing that there is no unordered relationship unidentified by the gamma correlations reported.

With these data available we can state without reservation that there is no relationship between the actual activities and accomplishments of the Area Boards and the members' evaluations of the boards. The hypothesis is disproven, as far as it concerns these actual activities and accomplishments. Individual Area Board members do not seem to value their experience as members on the basis of their boards' successes.

Individual Activities and Accomplishments of Area Board Members: An Analysis

The second approach to the hypothesis of this chapter is the question of whether members' own activities and accomplishments as members of their boards are related to their evaluations. For this section we will employ the two variables concerning initiation of new programs and the launching of such programs.

Taking the first variable first, we find that there is no discernible relationship. Each of the gamma correlations is near zero, and significance tests show that none of the relationships is important. We can say without doubt that the experience of initiating new programs does not have any bearing of members' evaluations of their boards.

Success in partially or fully launching new programs and services shows similar results in the two categories of member evaluations. Success in launching programs has nothing to do with members' decreased confidence in the usefulness of Area Boards or with their decreased belief that the Area Board form of citizen participation will work.

The results of this part of the analysis do nothing to support the hypothesis that members' evaluations result from inactivity and lack of personal accomplishment. Once again we must suspect that other factors take precedence, and these will become evident as the analysis proceeds.

Conclusion

In this chapter we have thoroughly demonstrated the inadequacy of the hypothesis that Area Board members' evaluations of their boards are related to the fact that the boards have failed to succeed in implementing their accomplishment role. The boards have, in fact, accomplished a great deal. We also demonstrated the lack of statistical association between the accomplishments of boards and the evaluations their specific members make.

This conclusion was further supported when it was found that the hypothesis also did not apply to individuals' participation in board accomplishments. There was no tendency for members who personally contributed to board accomplishments to maintain a higher evaluation of boards than those members who did not so contribute.

The implication of this conclusion for a determination of the criteria citizen participants use in evaluating citizen participation must be clear. There is no support for the hypothesis, advanced by many board members and an experienced scholar, that accomplishments of an organization are associated with evaluations. Thus at least in the case of the Area Boards of Massachusetts, board accomplishments are irrelevant to members' evaluations. We must look to other hypotheses.

CHAPTER SIX

ROLE ENACTMENT, ROLE AMBIGUITY AND MEMBERS' EVALUATIONS

In the preceding chapter we tested and rejected the hypothesis that members' evaluations of their boards are based on the extent of overt, measurable accomplishments. We found that, although many boards have developed a substantial record of accomplishments along several dimensions, this has not had an impact on the way members feel about the usefulness and workability of the Area Board system of Massachusetts. We found that we will need to look further into the question of members' evaluations.

In this chapter we will consider two further hypotheses: that members' perceptions of the enactment of the role of their board are associated with their evaluations, and that members' ambiguity about the role of the boards is responsible for members' evaluations. These two hypotheses will be consulted in turn.

Role Enactment

During the early stages of this research, before questionnaires were prepared or distributed, many Area Board members and

interested observers commented that the role of the boards had not been properly implemented. These individuals reported that members often experience disappointment and frustration because "the boards haven't even done the things they were duly empowered and required to do."[1]

This common complaint of members of the Area Boards and of observers is an important, empirically based reason to investigate this process of role enactment for the boards. However, the hypothesis is further suggested by the same theoretical reasoning employed in Chapter Five. In Chapter Five it was hypothesized that members' evaluations are related to accomplishments in the way that any organization can be expected to respond to measurable success. In this chapter we consider board members' perceptions of the successful enactment of the role of the board as a special case of measurable success. After all, one of the earliest jobs of any board is to implement its role; failures to do so could be expected to coincide with the kinds of comments reported above--comments that the members are disappointed by the failure of their board to implement its appointed role.

In order to test this hypothesis about the relation of successful role enactment to members' evaluations of the boards, we will first look at the level of enactment perceived by members and at the legal

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[1]Quote from an Area Board member interviewed by this investigator in October, 1969.

basis for expecting to see each such aspect of the role. We begin with the general purposes of the boards as described in Chapter Four.

General Purposes of the Area Boards:

As the range of models in Chapter One would suggest, there are many different possible purposes for Area Boards, but for this analysis we are concentrating on three general purposes: advice to the Department of Mental Health, oversight of services, and policy decision-making. These three seem to cover a broad range of specific purposes and provide a solid foundation for our proposed analysis. Readers wanting a more complete review of the meaning of these three purposes are referred to Chapter Four.

Our first task in this segment of the analysis to to outline the perceptions Area Board members have of the enactment or implementation of these parts of the role of the boards. Members were asked to say whether it was a general purpose of their board to carry out the functions of advice, oversight, and policy decision-making. Their responses were recorded as "yes it is," "not it is not," or as "uncertain." The questions and their resulting frequency distributions are indicated in Table 5 below.

Because we are trying to put these perceptions of role enactment in perspective with the legally defined expectations or possibilities of role, let us review the legal role of the boards presented in Chapter Two. In Chapter Two we found that there is no barrier to the advisory function of Area Boards. Indeed, the second enumerated purpose of the boards, as presented in Your Area Board, is "to advise

TABLE 5

THE GENERAL PURPOSES OF THE AREA BOARDS[a]

Purpose	Is	Is Not	Uncertain
Advise the Department of Mental Health as to what mental health and retardation services are needed in the area	71% (304)	12% (52)	17% (72)
Oversee the provision of mental health and retardation services in its area and raise its voice when it disapproves of activities observed	40% (169)	30% (125)	30% (125)
Make policy decisions on matters relating to the provision of mental health and retardation services in its area	33% (139)	33% (138)	34% (144)

[a]The N for each distribution is 440 less the blanks, 12, 21 and 19, respectively.

regarding local needs and resources in the development of comprehensive mental health and retardation services."[1] Similarly, many subsequent references to duties and powers from the same list begin with some reference such as "to advise ...," or "to consult with ..." Thus there is little room for doubt concerning the legitimacy of the advisory function.

[1]Massachusetts Department of Mental Health, Your Area Board, op. cit., p. 33.

There is also little question about the legitimacy of the oversight function. The mandate for the oversight function requires a bit more inference, the function being considered more peripheral than the advisory function, but it is still clear.[1] In the list of legal duties and powers mentioned above, the power of oversight is implied in almost every statement. For example, it says that the duties and powers include the responsibility to "review arrangements and contracts for programs and services which are a part of the program of the area ..."[2] The statement does not offer any suggestion as to the responsibility of the boards should they find fault with arrangements, but recourse of advice to the Department and further political action is always possible. Further evidence to support this function is provided in the introduction to Chapter Five of Your Area Board. This introduction describes some specific functions, particularly recommendations on selecting area directors and associate area directors, as well as approving the annual plan and budget, and continues, "Over and above your legal responsibilities, however, is the more subtle, but equally important role you can assume as the strong citizen voice for good mental health and retardation programs in your community."[3]

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[1] By "Oversight" we mean the right and duty of the boards to keep themselves informed about mental health and retardation services in their respective areas and to take action to remedy any deficiencies noted.

[2] Massachusetts Department of Mental Health, Your Area Board, op. cit., p. 33.

[3] Ibid., p. 30.

The policy decision-making function is not granted to the Area Boards by law. In fact, the Area Boards were established as part of a larger policy, and the boards are committed by law to the support of the community mental health approach to services. It is stated early in Your Area Board that, "You, as an Area Board member, will help to implement the new community mental health and retardation program."[1] Whatever enactment of Area Board role that members see as policy decision-making must be the result of acceptance of advice by the Department of Mental Health. That is, it must be cases where the board makes a policy decision which it then puts to the Department as advice, and which the Department or its representative seems to accept. Thus the policy decision-making function of the boards is not a legally prescribed function, but a by-product of expansive actions by the boards.

Looking at the frequency distributions on the general purposes of the Area Boards (Table 5 above), we find that the enactment of role, as perceived, has not gone precisely as anticipated by the law. Area Board members see less than full enactment of their advisory function, even less on their oversight function, and more than would be expected by law on the policy decision-making function. We can say that the legal aspects of the Area Board role are under-enacted, while the extra-legal aspects are over-enacted. The frequency distribution for general purposes of the Area Boards shows

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[1] Ibid., p. 3.

that members see uneven implementation of their role relative to the law. Members clearly see role enactment taking place in variation from the purposes expressed in Your Area Board.

The picture of perceived enactment shows, therefore, two of the general purposes under-enacted and one over-enacted. This difference will have some impact on the analysis, adding a new dimension to the hypothesis. While before we spoke only of a deficient enactment, we are now observing the opposite possibility, too. We will return to this point in the analysis below. Here we continue to review the legal foundations and perceived enactment for a few practical (specific) aspects of the Area Board role.

Practices of Area Boards:

The practices of Area Boards presented to members in our questionnaire are specific examples of tasks which might possibly be performed by Area Boards. Only one of these practices has explicit official sanction in the form of a mention in Your Area Board. The one practice officially mentioned is to "approve or reject Area Plans ..." But the other three practices were included because early interviewing showed them to be frequently mentioned aspects of the role of Area Boards.

Each of the practices presented to the members on the questionnaire is clear from the question asked. The first two (see Table 6 below) require board initiative in program development. The latter two are strong powers to be wielded by the boards.

The extent to which board members perceive the boards carrying out these practices will be further evidence on the enactment of the Area Board role. When members see their board as approving area plans, they will be enacting the legal role. When they are fulfilling other functions, they will be seen extending the role. Frequency distributions on perceived Area Board practices are presented in Table 6 immediately below. The response categories are identical with those of general purposes.

TABLE 6

PRACTICES OF AREA BOARDS

Practices	Is	Is Not	Uncertain
To plan and initiate new mental health or retardation services	55% (231)	25% (107)	20% (84)
To approve or reject area plans presented	45% (187)	23% (94)	32% (133)
To sponsor programs to educate the public about the problems of mental health and retardation	30% (124)	50% (211)	20% (85)
To allocate mental health and retardation funds within the area	15% (64)	58% (242)	27% (111)

The distributions of perceptions of board practices indicate that none of the four practices is dominant across boards, and that the most frequently reported practice is one of those not included in the formal list of functions of Area Boards. Thus we see again

that the enactment of the formally specified role of the board is not especially strong and that a practice not formally specified actually seems to occur more often than the formally specified practices.[1]

One further point of interest is indicated by the high level of uncertainty about whether the board does or does not practice the functions described. This is also true for the general purposes presented above. Thus role enactment is marked by significant uncertainty, a fact which will be considered in greater detail below.

Altogether, the purposes and practices of Area Boards, as perceived by members, suggest that the role enactment thus far is weak. We see that some of the formally specified aspects of role are still not widely implemented, while some aspects not specified are fairly widely implemented. We see a picture evolving in which role enactment could, indeed, be the source of members' declining evaluations of this quasi-governmental form of citizen participation.

Role Enactment and Members' Evaluations:

We have hypothesized above that members' evaluations of their boards are related to the success of their boards in enacting the formally specified role of the boards. Then we found that this success has been limited, that other than the formally specified aspects of role have been at least as successful as some of the formally

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[1]The terminology here is difficult. We will refer hereafter to these as formal and extra-formal specifications.

specified aspects, and that many members were uncertain about the extent of enactment which has taken place. Thus we find the picture of role enactment complicated, but with the kind of features which support the possibility of the relationship hypothesized--i.e., that things have not gone exactly according to the formally specified plan. We will now test the hypothesis that the success or failure of role enactment as perceived by the board members will affect the evaluation the members make of their boards. A table of gamma correlations (Table 7) follows.

As the reader will see, the relationships described in this Table show general confirmation of the hypothesis. There is a consistent relationship between successful role enactment and members' positive evaluations on the one hand and unsuccessful role enactment and negative evaluations on the other. As the role of the boards is enacted, evaluations remain strong; as the role is not enacted, the evaluations drop. We have the beginnings, then, of an explanation of members' evaluations. However, there is much more to this analysis than overall confirmation. We must look at this set of relationships in greater detail.

First of all, we note that the hypothesis is equally well confirmed for each of the two dependent measures. There are variations and some relationships are stronger than ever, but there is no obvious pattern which detracts from the conclusion. We might also mention the fact that the average gamma correlation for the seven relationships for each dependent measure are -.30 and -30 respectively.

TABLE 7

ROLE ENACTMENT AND MEMBERS' EVALUATIONS[a]

Evaluations	Area Boards are a useful contribution to the MH and MR system	The Area Board form of citizen participation will work
Perceived General Purposes:		
Advise	-.22[b]	-.34[c]
Oversight	-.43[c]	-.26[c]
Policy decision-making	-.37[c]	-.34[c]
Perceived Practices:		
Sponsor public education	-.25[c]	-.21
Planning and initiating services	-.22[b]	-.24[b]
Review and approve area plan	-.31[c]	-.24[b]
Allocate area funds	-.29[c]	-.49[c]

[a]Coefficients are gamma correlations

[b]Significant at the .05 level

[c]Significant at the .01 level

Average correlations are a seldom used analytical tool, but they are useful here as they show the similarity of the strength of confirmation of the two aspects of the hypothesis.

The strongest relationship observed in the "useful contribution" measure of evaluation is the oversight function. It seems that when boards do not appear to members to conduct oversight over

programs, there is a strong tendency for members' evaluations to drop. Although oversight is an inferred legal power of the boards, its failure is especially important to the members. We suspect from this that members take their oversight function seriously, a viewpoint which would seem confirmed by lengthy discussions with Area Board members.

One more small point is the strong gamma correlation between the practice of allocating area funds and the belief that the Area Board form of citizen participation will work. Members seem to consider this practice especially important. And we know from attendance at Area Board meetings that the failure of the legislature and Department of Mental Health to grant this power is a frequent cause for members' complaint. When members do not have the chance to allocate funds, they are likely to decrease their evaluations concerning the workability of the boards.

The next step in interpreting the relationships between role enactment and members' evaluations is to compare the levels of confirmation of the formally specified and not-formally specified forms of enactment. That is, we want to know if the formally specified aspects of the role are more important to the members than those not formally specified. We will want to consider the table of relationships in another form (Table 8). Again we use the average gamma as a means of presenting an overall picture.

We see there is no overall difference in the confirmation of the hypothesis when the measures are divided into the formally

TABLE 8

ROLE ENACTMENT AND
MEMBERS' EVALUATIONS REORGANIZED[a]

Role Enactment	Boards a useful contribution	Area Board form of citizen participation will work
Formally specified[1] aspects of role enactment	-.32	-.28
Not-formally specified aspects of role enactment	-.28	-.32

[a]Using average gammas

specified and the not-formally specified aspects of the enactment of role. The not-formally specified measures seem to be as important to members' evaluations as the formally specified measures.

Summary:

We have considered the various aspects of the hypothesis that the success of enactment of the Area Board role is an important determinant of members' evaluations of their boards. We found that the enactment is perceived by board members to be limited, that as much has been done outside formally specified aspects of role as inside, and that members are often uncertain about the levels of enactment which have taken place. Then we tested the hypothesis and found it confirmed, and confirmed equally for both dependent measures of

[1]Formally specified aspects include: advice, oversight, sponsorship of public education, planning and initiation of services, and review of the area plan.

members' evaluations. Further, it was shown to be equally confirmed for the formally specified and the not-formally specified role enactment.

Taken together, these various pieces of evidence show that the perceived successful enactment of role is an important criterion for members' evaluation of citizen participation. This is an important conclusion, although it might still be modified as we look at the other hypotheses related to the role of the Area Boards.

Role Ambiguity

The role ambiguity hypothesis to be considered here has, as do the other hypotheses, an empirical as well as a theoretical origin. It is an hypothesis strongly supported by many Area Board members and interested observers, and rather directly suggested by literature coming out of the federal "war on poverty." We will review the hypothesis, describe its two points of origin, and then continue on to test the hypothesis.

The role ambiguity hypothesis states that uncertainty or ambiguity about the role of the Area Boards is inversely related to members' evaluations of their boards. That is, when ambiguity is high, it is likely that the members' evaluations will decline. It means in practice that certainty about the role of the boards is in and of itself a positive criterion for members looking at their boards. It means that board members want to have a clear idea about the role of their board and, if they do not have such a clear ideal,

they are less sanguine about the usefulness and workability of their boards.

Ambiguity, as we will use the term here, means uncertainty or a lack of clarity about the various purposes and relationships important to the role of the boards. We have found it necessary to consider several different forms of role ambiguity, that is, ambiguity on several different purposes and relationships, since it seems that members think in these terms.[1] However, each of the measures of ambiguity is closely related to the others, and we feel we can speak also of a general concept of ambiguity.

The empirical base for the role ambiguity hypothesis is typified by members' comments that, "we don't know what we are doing here," and "what's the good of our coming here every month if we don't even know what we are supposed to do." Members and observers often commented that they didn't know where the boards were intended to fit in the larger mental health and retardation system, and that, if the boards couldn't figure out their role, the members would all give up on their attempts to participate. Their feelings were well exemplified in this investigator's first visit to an Area Board meeting, in which the members divided up into three groups to see if they could decide what the role of their board might be. Then, after an hour's discussion, each group reported back without conclusions. They had many specific suggestions, but for each suggestion they knew

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[1]This was ascertained in discussions with Area Board members in the early phases of the research.

the limitations which exist on any board action. So finally, the meeting concluded amidst numerous angry comments about the Department of Mental Health, the Commonwealth of Massachusetts, and citizen participation in general.

The theoretical sources for the ambiguity hypothesis grows, as we mentioned above, out of literature on the war on poverty. This literature has paid attention to the broader problems of citizen participation by low income individuals in governmental programs as well as such topics as "role enactment" for OEO Community Action Agency "volunteer indigenous leaders" and "poverty boards."[1] Poverty investigators have concluded that "one of the greatest problems experienced by the nonprofessional is role ambiguity or lack of role identity."[2] The nonprofessional finds, according to Riessman, that "he is no longer a simple member of the community if he ever was one, nor is he a professional. Actually, he is a highly marginal person ..."[3] The nonprofessional's role, then, is unclear.

When the nonprofessional or the low-income participant on a poverty board finds that he is unclear about his role, he tends to need a substantial amount of professional leadership and a period of time to come to terms with his role ambiguity. If he does not get

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[1]Louis A. Zurcher, Jr., "The Poverty Board: Some Consequences of 'Maximum Feasible Participation,'" (Austin: University of Texas, April, 1968), unpublished mimeograph.

[2]Frank Riessman, "Strategies and Suggestions for Training Nonprofessionals," (New York: Department of Psychiatry, Albert Einstein College of Medicine, 1966). Mimeograph.

[3]Ibid., p. 6.

this time and assistance, he can easily lose interest in the process in which he is participating, or become an antagonist for that process.[1]

Our hypothesis deals with the reactions of individual members to a group role--that of the Area Board. But the similarity of response between the individual and group expressions can be expected to be close. Thus the research on role learning and adaptation by low income residents can be applied to our research.

Although the poverty research is directed at an entirely different socio-economic strata from that which we have encountered on Area Boards, the hypothesis is still suggested. There is no research to indicate any different reactions to ambiguity on the part of higher socio-economic nonprofessionals than on the part of those nonprofessionals involved in poverty leadership or program participation.

In the section below we will look in more detail at the role ambiguity perceived by Massachusetts Area Board members. The responses of members who were asked about the various aspects of role considered will enhance our understanding of the environment of the boards as seen by their members and will set the stage for a test of the hypothesis.

Role Ambiguity as Perceived by Members:

A series of ten separate questions were used to assess the level of role ambiguity perceived by Area Board members. The first

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[1]Louis A. Zurcher, Jr., "Stages of Development in Poverty Program Neighborhood Action Committees," Applied Behavioral Science, Vol. 5, No. 2 (1969), 223-258.

two were designed to reflect the members' perceptions of his or her general role ambiguity at the time of joining the board and the general ambiguity at the time of the questionnaire completion. Then the questions were compared, as described in Chapter Four, and a measure of ambiguity change constructed.

The purpose of the ambiguity change measure was to increase our understanding of the ambiguity phenomenon. It was to be expected that new board members would experience a general ambiguity about the role, and it was important to separate this out from a residual ambiguity described by many experienced members.

Our index of ambiguity change showed clearly our expectation that some ambiguity would decrease with experience. Exactly half of the members felt that their ambiguity had decreased between the time they joined their boards and the time of the questionnaire. It was somewhat less in accordance with expectations to see forty-five percent of the members not decreasing their ambiguity and five percent actually increasing theirs. But there is evidence of a general learning about the role of the boards, and the remainder of the measures of ambiguity can be read as a more detailed report on the ambiguity after some significant learning.

In Table 9 below we have reported the levels of ambiguity perceived by Area Board members at the time of the questionnaire. The reader will note that the levels of ambiguity show a substantial range. But at the same time it lends power to the feelings expressed by members, observers, and poverty investigators that role ambiguity

TABLE 9

RESPONSE FREQUENCIES
FOR ROLE AMBIGUITY QUESTIONS

Ambiguity Concern	Ambiguity	N
General Purposes	37% (148)	401
Relation to Area Citizens	53% (200)	380
Duties and Responsibilities	56% (224)	403
Relation to Local Facilities	64% (247)	389
Relation to Regional Office of the Department	66% (245)	373
Relation to Mental Health and Retardation Associations	67% (252)	375
Relation to Central Department of Mental Health	73% (276)	378
Power and Authority	81% (326)	404

runs high for citizen participants in new systems. For there is a significant level of ambiguity indicated by the Table.

Role Ambiguity and Members' Evaluations:

Once again, the data used to test the hypothesis in question is best presented in a table of gamma correlations. In Table 10 we have arranged the various measures of ambiguity vertically and the two measures of members' evaluations horizontally.

The frequencies in this Table make it clear that at least one part of the hypothesis is valid: Role ambiguity is strongly and

TABLE 10

ROLE AMBIGUITY
AND MEMBERS' EVALUATIONS

Ambiguity Concern	Boards are a useful addition	Boards will work
General Purposes	-.40[b]	-.28[b]
Relation to Area Citizens	-.34[b]	-.09
Duties and Responsibilities	-.39[b]	-.25[a]
Relation to Local Facilities	-.37[b]	-.30[b]
Relation to Regional Office of the Department	-.33[b]	-.15
Relation to Mental Health and Retardation Associations	-.28[b]	-.18
Relation to Central Department of Mental Health	-.49[b]	-.43[b]
Power and Authority	-.43[b]	-.18

[a]significant at the .05 level
[b]significant at the .01 level

negatively related to members' evaluations of the usefulness of the Area Boards. That is, role ambiguity is related to decreases in the evaluations members make as they serve on the boards. Every possible measure of ambiguity shows a strong relationship with the members' negative perceptions of the usefulness of the board.

Strongest among the relationships in this Table are those for the ambiguity of power or authority and the relationship of the boards to the Department of Mental Health. These two measures, both being over -.4, indicate the importance of defining the more basic issues of the boards' roles. It is exactly in the realm of power and authority, a realm legally entrusted to the Department to define further, that induces members to decrease their evaluations of the usefulness of the boards. The members seem to be saying that, when the boards' powers and authorities are not defined by the Department of Mental Health, the usefulness of the boards declines.

The second part of the hypothesis is less well demonstrated. Only four of the relationships seem important: general purposes, duties and responsibilities, relationship to the central department and to local facilities. The rest are only slightly significant, or are not significant at all.

We are surprised by this rather spotty confirmation of the hypothesis that the Area Board form of participation will work, and we are unable to offer a single cogent reason for the pattern observed. We might speculate on a few reasons, but they must be tentative until some further evidence presents itself.

A tentative explanation is the difference between what will work and what is useful. There are many things in the world which will work but not be useful. Perhaps we are faced with a situation in which the workability of the boards can survive role ambiguities but usefulness cannot.

If the Area Boards are to work, we see, they must be fairly clear about general purposes, responsibilities, and their relation to the central Department of Mental Health, as well as its direct services. By this token the powers of the boards, or clear relations to departmental administrative offices, local associations and citizens are not very important. Thus we see a picture in which the boards will work if members only know what they are responsible for in general and how they relate to direct services. But to be useful, the boards' powers and relations to constituencies must also be clear.

Conclusions:

We found in this analysis that the role ambiguity hypothesis is essentially valid. Role ambiguity as perceived by members does have a detrimental effect on members' evaluations of the usefulness and workability of their boards. However, we also found some limitations on this hypothesis in that it is more true for usefulness than workability. It seems to be the case that the boards will work even with role ambiguity in some categories while all ambiguity decreases boards' usefulness.

CHAPTER SEVEN

ROLE CONFLICT AND MEMBERS' EVALUATIONS

In the last chapter we obtained confirmation of our two hypotheses that role enactment and role ambiguity are associated with members' evaluations. It was found that, as role enactment, as perceived by the Area Board members, fell short of the expectations established in the legislation, members' evaluations of their participation tended to decrease. Similarly, it was found that role ambiguity increased the likelihood that members would revise their evaluations of their boards downward. Consequently, we have been able thus far in this dissertation to say with assurance that two role-related dimensions of Area Boards serve as criteria members use in evaluating their experiences in citizen participation on Area Boards.

With these facts behind us, it is time to approach the fourth and final hypothesis outlined in Chapter One: that role conflict produces negative evaluations by board members. The reader will remember from Chapter One that several citizens interviewed in early parts of the research expressed strong feelings about the multiplicity of expectations placed on them in their roles as Area Board

members, and suggested that such feelings often produced adverse effects on board membership and participation. The reader will also remember that the formulation which grew out of these citizen comments, namely that role conflict has a negative influence on members' evaluations, was found to be supported by the research results of Gross and his associates as they looked at the school superintendency role in Massachusetts. Thus by combining empirical and theoretical evidence we were able to articulate a likely hypothesis for this research.

Before we break this hypothesis into its several forms, it would be useful to place it in context with the two hypotheses previously supported. For this hypothesis is closely related to, and builds on, the work of the preceding chapter.

The role enactment hypothesis was founded on the perceptions members had of the enactment of the practices and purposes explicitly laid out for the boards by Chapter 735 of the Massachusetts Legal Code. It was also, in a sense, an example of role conflict: conflict between the perceived actual role and the role prescribed by law. As we proceed, the reader will see that the role conflict measures represent similar, but more sophisticated, examples of this same type. That is, they will both be conflicts between members' perceptions of the actual role of their board and some standard of comparison other than the law.

Role conflict as discussed in this chapter also differs substantially from the role ambiguity discussed previously. Role

ambiguity, as measured, reflects the members' inability either to know the legal limits of the Area Board role or to successfully substitute some other standard for the legal specification. Role conflict, on the other hand, implies a very sharp specification of another standard, for it is a measure of difference between the actual role as perceived and one of several alternate sources of standards. When we have completed this chapter, the distinctions will be much clearer, and we will be closer to knowing what criteria citizens use to evaluate citizen participation.

The role conflict hypothesis we have developed has two parts. Perhaps it is best expressed by the comments of citizens themselves when they said:

> We never know where we stand. The department wants us to do one thing; the associations want another; and people in my neighborhood keep asking me what we are doing.[1]

and

> I know exactly what we should be doing; they /the legislature and/or the department/ just won't let us do it.[2]

Thus we see an immediate separation between two kinds of standards, one that comes from relevant individuals or groups and one that is internal to each individual member. These will be tested separately and in the order presented above.

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[1] Respondent's questionnaire, see Appendix A.

[2] Ibid.

Theoretical formulations from the literature are best exemplified by the formal hypothesis quoted in Chapter One:

> Position incumbents who perceive that they are exposed to role conflict will derive less gratification from the occupancy of their position than position incumbents who do not perceive that they are exposed to role conflict.

Translated from an individual's role to a board's role, the hypothesis becomes "members of Area Boards subjected to conflicting expectations are more likely to decrease their evaluations of their board than those belonging to boards without such conflicting expectations."

The above hypothesis is recommended by other theories. Part of our approach to role conflict is based on the contrast between what <u>is</u> and what <u>should be</u> the case according to the perceptions and beliefs of the members. It is, in other words, a conflict between the actual and ideal of the boards--a kind of conflict described by Davis and Fieraband. These investigators have looked at the broad hypothesis that social dissatisfaction is a product of the increasing gap between what the dissatisfied social group perceived to be their social role and what they feel their role should be. The confirmations they have obtained suggest the value of their hypothesis and its potential value for this research.

Conflicting Expectations: Levels of Conflict

In formulating this segment of the hypothesis, we determined from extended discussions with board members and informed observers

that there were seven individuals or groups who could be considered important reference groups for the Area Boards. They represent each of the public and private elements of mental health and retardation which come in regular contact with the Area Boards. These individuals and groups are the Central Department of Mental Health, local mental health and retardation facilities, regional mental health administrators, acting area directors or associate area directors, local mental health or retardation associations and area citizens. Thus there are seven important sources of conflicting expectations.

Simple frequency distributions will be presented in Table 11 to show the extent to which members felt that the seven reference groups expected them to perform each or any of the three major purposes of Area Boards. Next, Table 12 will show the frequency distributions for what board members believe the role of their board should be--that is, the ideal role of their board. This will, in turn, be followed by Table 13, which indicates the number of members who felt conflict between their own expectations or ideal and those of their boards' reference groups.

The reader will note in the first of these Tables that a large number of members do not feel that their significant reference groups perceive a strong role for the Area Boards. In few cases does a simple majority of the members feel that any of the three functions are expected of their boards. Not even in the case of the advisory function do members feel that their significant reference groups support them in carrying out their role. The oversight function is even

TABLE 11

FREQUENCY DISTRIBUTIONS FOR PERCEIVED EXPECTATIONS OF SIGNIFICANT REFERENCE GROUPS: BOARD PURPOSES

	Purpose		
Reference Group	Advice[a]	Oversight[b]	Policy Decisions[c]
Staff of CDMH	55 % (240)	18% (75)	11% (46)
Local Facilities	52 % (230)	21% (87)	21% (86)
Regional Administrator	59 % (258)	23% (96)	26% (111)
Area Director	60 % (264)	28% (111)	35% (142)
Local MHA	47.5% (209)	25% (105)	28% (117)
Local ARC	49 % (216)	27% (111)	24% (98)
Area Citizens	20 % (89)	13% (56)	9% (39)

[a] Ns = 440

[b] Ns = 420, 417, 420, 401, 413, 417, 420, respectively

[c] Ns = 419, 417, 420, 401, 413, 416, 418, respectively

TABLE 12

FREQUENCY DISTRIBUTIONS ON BOARD MEMBERS' IDEAL FOR AREA BOARDS: PURPOSES AND PRACTICES

General Purposes	Should Not Be	Uncertain	Should Be	N
Advice	1% (3)	2% (10)	97% (404)	417
Oversight	4% (15)	11% (46)	85% (355)	416
Policy-Making	6% (23)	18% (75)	76% (318)	416
General Practices				
Sponsor education programs	5% (21)	7% (31)	88% (367)	419
Plan and initiate new services	4% (15)	9% (37)	87% (362)	414
Review area plan	3% (12)	12% (48)	85% (353)	413
Allocate funds	9% (37)	26% (108)	65% (273)	418

TABLE 13

FREQUENCY DISTRIBUTIONS FOR CONFLICTING EXPECTATIONS:
BOARD PURPOSES

	Purpose		
Reference Group	Advice[a]	Oversight[b]	Policy Decisions[c]
Staff of CDMH	60% (262)	66% (290)	63% (278)
Local Facilities	55% (243)	63% (277)	54% (237)
Regional Administrator	49% (215)	61% (270)	51% (224)
Area Director	45% (197)	59% (258)	45% (200)
Local MHA	56% (248)	60% (262)	50% (220)
Local ARC	55% (240)	57% (251)	52.5% (231)
Area Citizens	80% (354)	70% (309)	65% (285)

[a] Ns = 440

[b] Ns = 440

[c] Ns = 440

less frequently seen as an expected function, and the same is true of the policy decision-making function. Although we see no way in which these data suggest that members could get the feeling of extensive expectations for the Area Boards, Table 12 shows clearly that the board members take a very strong position on what the role of their boards ought to be. The members believe that their boards shoudl advise the Department of Mental Health, oversee services, and make policy decisions. They also feel that their boards should carry out each of the four practices listed. Even in the case of the allocation of funds, a majority of the members feel the practice is appropriate. The members of the Massachusetts Area Boards have unequivocally stated a preference for a strong role.

In Table 14, the final Table in this series, that for conflicting expectations, we see that the levels of conflict between what the board members perceive to be the expectations of reference groups and their own preferences are high. There are subtle differences among the many percentages in this Table, but no significant pattern appears, aside from the major conclusion that there is a great deal of conflict. Using the data outlined above, let us now test our first hypothesis.

Conflicting Expectations and Members' Evaluations

Looking at Table 14, we begin by considering the relationships between conflicts involving the advisory function and members' evaluations. These are to be found in the first two columns

TABLE 14

CONFLICTING ROLE EXPECTATIONS AND MEMBERS' EVALUATIONS
(Decimal numbers are gamma correlations)

Reference Group	Advisory Function		Oversight Function		Policy Decision-Making Function	
	Useful[a]	Workable[b]	Useful[a]	Workable[b]	Useful[a]	Workable[b]
Staff of CDMH	-.39[d]	-.37[d]	-.28[d]	-.30[d]	-.29[d]	-.17
Local Facilities	-.28[d]	-.21[c]	-.25[c]	-.26[c]	-.24[c]	-.09
Regional Administrators	-.19	-.28[d]	-.29[d]	-.31[d]	-.35[d]	-.20
Area Directors	-.23[c]	-.35[d]	-.26[d]	-.28[d]	-.17	-.04
Local MHA	-.10	-.17	-.20[c]	-.11	-.13	+.04
Local ARC	-.28[d]	-.21	-.27[d]	-.15	-.13	+.02
Area Citizens	-.43[d]	-.50[d]	-.16	-.21[c]	-.08	-.02

[a]Area Boards are a useful addition to the mental health and retardation system

[b]The Area Board form of citizen participation will work

[c]Significant at the .05 level

[d]Significant at the .01 level

In the first of these two columns we see that several measures of conflicting role expectations are strongly related to the usefulness of Area Boards. We are especially struck by the apparent strength of expectation conflicts with the staff of the central department and with area citizens. The first of these (at -.39) and the second (at .43) are clearly important for confirming the hypothesis that conflicting expectations have a strong negative impact on members' evaluation. These are strong signs of confirmation. It is interesting that the two reference groups are at opposite ends of the spectrum of constituencies: one, the most central representative of official santion; the other, the broadest based legitimizing agent of all. But we cannot make too much of this pattern of relationships, for it does not carry through in other results seen in this research. We must be satisfied to say that the hypothesis about role expectation conflicts and members' evaluations confirmed for this measure of members' evaluations. Similarly, it is confirmed for the "workability" measure of evaluations.

Examining the oversight function as a basis for conflicting expectations, we see further confirmation of our overall hypothesis about conflicting expectations and members' evaluations. In this category of relationships we note the division between conflicts involving the mental health bureaucracy and those involving citizen groups. When the citizens feel that the state representatives want to exclude the boards from the oversight function, while they

themselves want to perform the functions, the members' evaluations decline.

In the case of the policy decision-making function, we see a change. This set of relationships is generally lower than the previous sets. Or at least, this is true of the workability column. Conflicting expectations on policy decision-making have nothing to do with members' evaluations of the workability of the boards. But once again the conflicting expectations hypothesis is confirmed for conflicts with most representatives of the Department of Mental Health. Thus, even in this set of relationships, the hypothesis is at least partially confirmed.

To sum up our conclusions, based on Table 14, the general hypothesis of conflicting role expectations influencing members' evaluations is confirmed. It is especially well confirmed for conflicts with representatives of the Department of Mental Health. It is not confirmed with regard to the private mental health or retardation groups or, except in the one great exception, for area citizens --the reason for this being, most likely, the greater sense of responsibility to the appointing authority, the state, than to private groups or a diffuse citizenry. Thus we can conclude that Area Board members are sensitive to the wishes of the Department of Mental Health and decrease their evaluations of the Area Boards if the Department's perceived wishes come in conflict with the members' own wishes.

Conflict of the Actual and the Ideal: Levels of Conflict

We have already discussed the various reasons which led us to consider the hypothesis that a conflict between a person's expectations and reality can cause a decrease in his evaluations of the object which fails to meet expectation. In this case we refer to the role of Area Boards and members' evaluations of their boards. Now we will test the hypothesis.

Table 15 below presents the frequency distribution for conflicts between the members' perception of the actual role of the board and the members' belief as to what the role should be. (See

TABLE 15

FREQUENCY DISTRIBUTIONS FOR ACTUAL/IDEAL CONFLICT

General Purposes and Practices	Conflict	N
General Purposes:		
Advise Department	17% (43)	258
Oversight	42% (87)	129
Policy-Making	44% (80)	180
General Practices:		
Promote Public Education	60% (136)	225
Plan and Initiate Services	28% (64)	227
Review Area Plan	32% (63)	197
Allocate Funds	74% (119)	160

Appendix C for information on variable construction.) It shows a reasonable amount of conflict, but conflict that varies substantially over different variables. We see that there is little conflict over the advisory function but a substantial amount for oversight and policy-making. On the practices there is variation, but the high point of conflict comes over the allocation of funds. Altogether, it seems that there is a basis for testing the hypothesis but no clear and special information available from the patterns of conflict seen in the frequency distributions.

Actual/Ideal Conflict and Members' Evaluations

Given the fact that the various measures of the actual/ideal conflict represent a sharply distinguished difference in perceptions of Area Board members, and an apparently important one, this investigator held high expectations for a strong confirmation of the hypothesis. And it can be seen by looking at Table 16 below that these expectations were met. There is strong and unequivocal confirmation that the conflict between what board members perceive to be the actual role of their boards and what they believe that role ideally should be is associated with negative evaluations. In fact, this is the strongest confirmation of a hypothesis yet obtained in this research.

Although the results reported in Table 16 are strong and clear in their meaning, there is a pattern of weaker relationships which deserves to be considered separately. This pattern includes

TABLE 16

ACTUAL/IDEAL CONFLICT AND MEMBERS' EVALUATIONS[a]

General Purposes and Practices	Boards are a useful addition	Area Board form of citizen participation will work
General Purposes:		
Advise Department	.297[c]	.507[c]
Oversee Services	.637[c]	.488[c]
Make Policy Decisions	.548[c]	.342[c]
General Practices		
Educate Public	.288[b]	.224[b]
Plan and Initiate Services	.259[b]	.332[c]
Review Area Plan	.453[c]	.427[c]
Allocate Funds	.444[c]	.686[c]

[a]All numbers are gamma correlations
[b]Significant at the .05 level
[c]Significant at the .01 level

two of the "practice" variables, public education activities and planning and initiating services, and both of the dependent measures. The relationships are weak here only in comparison with the basic pattern of the Table. And we can offer a tentative explanation for this relative weakness. That is, that these are secondary activities. Public education is often seen as a function of the private mental health and retardation associations, and thus less vital to board success. Planning and initiating services is, as we saw in an

earlier chapter, generally not a salient measure of board success in the minds of members.

Thus, to sum up the results of this phase of the analysis, the actual/ideal role conflict seems to be a vital factor in members' evaluations. Furthermore, we can be sure not that lack of such role conflicts are basic to citizens' criteria for evaluation of citizen participation. More will be made of these conclusions in the following chapter.

CHAPTER EIGHT

MEMBERS' EVALUATIONS AND THE CITIZEN IDEAL: A CONCLUDING ANALYSIS

It is the primary purpose of this dissertation to determine the criteria members of quasi-governmental citizen boards use to evaluate the usefulness and future success potential of this form of citizen participation. We have tested hypotheses derived from discussions with board members and backed by theoretical formulations from social science. But we have considered a great number of separate possibilities, and several of the possibilities have proven to be statistically important. Thus we will want to draw together the results of the chapters above and complete our analysis with a more refined answer to our main question than has been previously possible.

In a research effort of this kind, in which there are all too few clues relating the major independent variables one to another or putting them in a temporal sequence, it is difficult to get beyond the knowledge that there are multiple influences on members' evaluations. We know that certain factors show up again and again in separate parts of the analysis, but we have no way of definitively determining their importance. Thus, in this section of the dissertation

we are not claiming to have definitively interpreted the evidence and reached a fixed conclusion. However, we have developed a synthesis which does seem relevant and important to our topic, and we want to explore it as a tentative answer to the primary question of this research.

In successive chapters we have considered four kinds of possible influences on members' evaluations of their boards. One of these, the measurable accomplishments of boards, has turned out to be unrelated to members' evaluations. The other three are related. Let us review these three possible influences in turn.

The first influence is the state of role enactment of the boards. In analyzing this influence we found that almost any perceived failure to implement the role of the boards, whether a legal function or an inferred function, was related to decreasing evaluations of both the usefulness and the workability of the boards. In other words, members reacted against weak roles for the boards even when the stronger role exceeded legal stipulations.

The second influence was role ambiguity. Here we found that when board members were uncertain about the role of their boards their evaluations dropped. There were several special differences among the various types of ambiguity and among the two measures of evaluations, but basically we determined that role ambiguity led to lowered evaluations.

Finally, we found that two kinds of role conflict were related to members' evaluations. The first of these, members'

expectations which conflicted with those they perceived to be held by relevant reference groups within the mental health and retardation system, were strongly related to members' declining evaluations. Again there were specific variations in this conclusions, but the principle was established: when the reference groups were perceived to support a weaker role for the boards than the members themselves, their evaluations dropped.

The second form of role conflict was a conflict between what the members perceived to be the actual role of their board and what they thought it should be. This we called the actual/ideal conflict. And it proved to be the most strongly related influence of all. When the members' ideal of a strong board with a wide role came into conflict with the role as enacted, members' evaluations dropped.

We have reviewed these three influences to make the central characteristics clear. In each case they are concerned with the role of the boards. More specifically, they are concerned with the members' desires for a wide role, for a board with broad powers and responsibilities. This is easily seen in the different aspects of role enactment and role conflict, but it can also be argued that it is true for role ambiguity. Role ambiguity was more widespread than reported levels of uncertainty on specific aspects of role enactment or than the role ideal might suggest. We believe that this is a by-product of the same desire for a strong role that appears in the other role influences. We will elaborate on this point below; here we merely suggest this interpretation.

Having identified a single idea or concept that seems to be central to our purpose, we must try to clarify it further and to place it in a broader perspective. We must explore this idea that seems to be so important to members' evaluations.

The members' concept of a strong and broad role for the Area Boards is best referred to, as we have done previously, as the members' ideal of the role of the boards. It is made up of the responses reported in Table 12 of Chapter Seven. Its impact is directed toward members' evaluations only in conjunction with the particular state of other factors. That is, the ideal has no effect independent of the fact that the perceived enactment of role is substantially limited, or that the feeling is that relevant reference groups do not support the same ideal. The impact of the members' ideal takes force only in the context of an environment directed to a different end--that of a weak and limited role for Area Boards.

Having made the grand assumption that the members' ideal is the elementary concept, in conjunction with members' perceptions, that explains members' evaluations of their boards, we will want to know more about this ideal. Where does this ideal originate? How can we explain the fact that the ideal is stronger than the legal articulation? Is the ideal a product of lack of information about the legal role? Is it a product of members' experiences on the board? Or does it perhaps result from personal experiences or background factors of members?

In the sections that follow we will try to answer these questions. Some further delineation of the members' ideal is important to our conclusions about members' criteria for evaluating citizen participation. An understanding of this ideal will prove to have implications for the future of Massachusetts Area Boards and for the citizens' overall viewpoint on citizen participation on quasi-governmental boards.

Members' Use of Information Sources on the Role of the Boards

As we begin to look for possible explanations for the high ideal members hold for their boards, we would be wise to be sure that members were aware of the legal specifications of role. We do know from Chapter Seven that members did not believe that relevant reference groups expected the board to enact a very extensive role. But we cannot be sure that the members did not feel that the Department of Mental Health and its representatives, area and regional officials, were expecting a thwarted implementation of the legal role. It is quite possible that members see the Department as resisting the implementation of the Area Board legislation. Indeed, many members have so commented to this investigator and have so stated to a wider audience on public occasions. Thus we will want to see what sources of information were available to board members as they began their participation on their Area Boards.

A full picture of members' use of different role information sources is presented in Table 17. It includes all the sources we considered to be likely.

Of the sources listed in this Table, the pamphlet, Your Area Board, as well as the acting area director or associate area director and the regional administrator, can be expected to supply members with information on the legal role of the boards. Even if the Departmental staff do not agree with the role as specified in the law, they are required to transmit it upon request. Further, the exact legal specification of the role of the board is printed in Your Area Board.[1] Thus we can assume that, if members had access to the sources of information connected with the Department, they could be considered to have had means of learning the legal specifications of the Area Board role.

Table 17 illustrates that most members did have access to the various sources of information, and that these members considered the sources important elements in their orientation to the role of the boards. Access to the first source, the pamphlet, was nearly complete. Only six percent of the members did not have use of this source. Access to the acting area director, or the associate area director, was also substantial. Fourteen percent of the members did not have this access, but this is still relatively small. A slightly larger, but still relatively insignificant sixteen percent, did not

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[1] Massachusetts Department of Mental Health, Your Area Board, op. cit.

TABLE 17

MEMBERS' USE OF ROLE INFORMATION SOURCES[a]

Information Source[b]	Very Important	Important	Not Very Important	Not Available to Me	Don't Know or Can't Say	
Your Area Board	24%	41%	24%	6%	6%	N = 419
Acting Area Director or Associate Director	17%	33%	30%	15%	5%	N = 387
Regional Administrator	13%	28%	35%	16%	6%	N = 408
Fellow Board Laymen	15%	47%	32%	2%	4%	N = 416
Fellow Board Professionals	17%	49%	27%	5%	3%	N = 411
Fellow Board Members also in ARCs	18%	41%	33%	5%	3%	N = 413
Fellow Board Members also in MHAs	14%	44%	32%	6%	4%	N = 410
Board President	33%	36%	25%	2%	4%	N = 398
Predecessor on Board	6%	7%	23%	45%	18%	N = 324
Area Citizens	5%	12%	55%	14%	14%	N = 399

[a]Percentages are rounded to the nearest whole number

[b]See Appendix A for exact format

have access to the regional administrator. But in all these cases the percentages show that access to each of the sources was great. Thus, if members remain in ignorance of the legal specifications of role, an assumption which goes against all of the impressions formed by observers known to this investigator, we can assume that it is through neglect or misunderstanding, not because the specifications were not available.

Influences on the Ideal from Information Sources

In Chapter Seven we demonstrated that the perceptions members have of the expectations of relevant reference groups were important, in conjunction with the members' ideal, in affecting members' evaluations of citizen participation. Now we want to know if the information provided by our information sources, a group almost identical to the reference groups, has had an impact on the members' ideal of the role of the boards. For, although we know that the members' ideal differed substantially from their perception of expectations, we cannot be sure that the initial formulation of the ideal was not some function, even if its effect is inverse, of the original sources of role information.

To test this possibility we examined the relationships between members' uses of information sources, including the reliance they placed on each source, and the members' ideal. But there was no relationship at all. Area Board members seem to establish for

themselves an ideal of the role of the board entirely independent of the source or importance of the orientation they receive.

Personal Characteristics and the Members' Ideal

Another set of factors which might be expected to influence the members' ideal of the boards' role is the personal characteristics of members. Many political attitudes do vary according to such personal characteristics as age, sex, or education, and we must consider that possibility here.

The personal characteristics that will receive our attention include the three mentioned above as well as members' place in the life cycle, their income, occupation, length of residence in the area, and their exposure to mental illness or retardation in the family. We have chosen these because together they represent as good a sample of indicators of different socialization patterns and special interests as we have among personal characteristics. If differences in basic ideas about the role of citizen boards is a result of the differential learning in different periods of social or political history, that fact could be expected to show up in our analysis using such variables as age and the life cycle. If the members' ideal grows out of special interests, it should be represented by income, occupation, or education. And finally, as we might suspect, the special salience associated with the experience of mental illness or retardation within the family might cause the development of a specially strident view of the Area Board role.

Before we refer to our results in this segment of analysis, a word of caution is required. The selection process described in Chapter Two and the resulting narrowness of board membership, also described in Chapter Two, is a limiting factor in our interpretation of results. This is not to say that there is not substantial variation in members' personal characteristics (see Appendix D). But it suggests the variations are limited to within a specific range of the general population rather than to the entire population.

Results of this part of the analysis were entirely negative. There seems to be no relation at all between differences in basic personal characteristics of board members and their conceptions of the proper role of their boards. The members' ideal seems to come from some other source entirely.

Experience Prior to Membership and the Members' Ideal

Although the personal characteristics of members seem to be unrelated to their formulation of an ideal model of the Area Board role, it is possible that a simple but different set of factors might be important. These factors are experiences members have had prior to board membership, including civic participation, other kinds of public and private boards, mental health and retardation activities, and membership in mental health or retardation associations. These possibilities were tested. (See Appendix D for further information on these variables.)

Just as in the case of personal characteristics, there is no relationship between the experiences and memberships and the members'

ideal. The members' ideal once again seems to be independent of measurable differences among board members. Their preparations and identifications are irrelevant to their ideal of the role of the boards.

Experience on the Boards and the Members' Ideal

We have several variables to describe the experience of the members with their participation on their boards. These include the length of their membership, the members' level of activity during this membership, and the extent to which they demonstrated leadership in meetings or assumed the formal responsibilities of office holding.

Each of these variables offers possibilities for different kinds of feelings about the boards. We could expect, for example, that the members' ideal of the role would change with the length of participation, or with length and intensity, as they grew in their knowledge and understanding of their boards. However, this does not occur. None of these variables has any relationship to the members' ideal. (Again, see Appendix D for further information on these variables.)

A More Eclectic Explanation of Members' Ideal

From the evidence presented in the various sections above it is apparent that we can find no explanation for the nature of citizens' perceptions of the role of their boards in terms of data analyzed above. The expectation of a strong and active role for the boards seems to be an expectation which somehow pre-dates the members' participation on the boards. We also know that it is not related to any of the personal factors available to us. Thus we must look further for the explanation.

In looking further for this explanation, we can make the assumption that it is related to something both comprehensive and general. We can assume that it is something which affects almost everyone in the socio-economic strata from which the members come. It is also broad enough in character to affect a substantial range of specific issues--those used to define the role of the boards. What could this explanation be?

The simplest response to this question is to offer the term "socialization." This is a term sufficiently broad to include most means by which members of boards could learn the attitudes which shape their perceptions of the ideal Area Board role. We will want to look a bit further at the data available and attempt to isolate the kind of factor that might be involved. The answer, once suggested, will not be definitive; nor will it be rigorous. All of the solid information we have is negative, and we can only assume that we have eliminated most other reasonable solutions.

In responding to the questionnaire provided for them, a large number of Area Board members chose to add comments to the systematic responses they provided. These comments add a great deal in the way of depth to the study, and seem, to this investigator, to be a proper basis for a tentative answer to the question being asked here.[1]

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[1] N.B. The data used in pp. 154-157 are selected responses; they were not coded and compared analytically to the dependent variables being considered here.

In the paragraphs which follow we will look at some of the comments provided in this way. We will begin by looking at some members' own expressions of the problem as it seemed to them and will go on to pin down the kind of attitude which the comments seem to imply. None of the comments presented here can be considered isolated responses. For the most part they will be much like a great many similar comments for which there is insufficient room.

One of the most popular kinds of comments to appear was once expressed thus: "... it had to be clearly stated time and time again that the role of the board was that of an advisory body." This feeling was often expressed and is representative of the kind of basic expectation members have that the boards should be something more than advisory. It expresses the surprise of the members that the boards are not more powerful, and the difficulty members seem to have in altering their view. It is indicative of the conclusion from the data in the chapters above: The board members naturally expect more scope for their board than often comes.

Another comment, one which adds more detail and begins to point the way toward greater understanding of the role ideal of the member says, "We are important but we should be given more power and authority so that we can function in a way that will be more meaningful." This speaker, we know from his questionnaire, thought that the boards should have all of the powers listed in the questionnaire, from the advisory function to the right to allocate resources within the area. He also thought that his board already possessed

the power to advise the Department of Mental Health, and did so. But he wanted the boards to have a stronger role. And he justified his plea with the statement that only with this greater power and authority could the boards be more meaningful. He does not fall back on a specific principle of government, nor on an assumption that the boards are not making use of the power available to them. He is asking for a new grant of power and authority to make the boards more "meaningful."

This theme is developed more explicitly and cogently by another board member who also carries the topic on to a further point. He says, "The degree of participation and effectiveness is at present limited by the restrictions built into the basic legislation. New legislation is needed to impart greater responsibility and effectiveness to the role of the area board." Here we see the legislation defined as the basic culprit, and the justification for the greater power being that the effectiveness of the boards and the participation allowed to them is limited by the law. We can see a rather deep-set feeling of frustration showing up, a frustration that seems to grow out of the lack of effectiveness presently perceived by many members.

These comments reinforce our belief that members are restive essentially because their boards lack a sufficiently "meaningful" role and because they lack "effectiveness." But we also know from earlier chapters that the actual performance of the boards is substantial. Thus what concerns the members are not the actual achievements of the boards but something more, something that shows up in the following comment: "The main problem with the area board concept

is that the Great and General Court [i.e., the legislature] has given us much responsibility and limited authority--this is for the birds."

With this expression the picture begins to clear. To what these members refer when they speak of "meaningful" boards are boards to which the grant of responsibility is matched by a grant of power. Area Board members are reacting to a situation in which they are charged with a broad range of responsibilities, in fact with the oversight of the entire spectrum of mental health and mental retardation services for a large segment of the population, but are not given the tools to carry out their responsibilities.

There is another aspect to this problem. Not only is the responsibility assigned to the boards greater than the power allotted them, but also the board members are prepared by their backgrounds and expectations to bear the responsibilities conferred upon them. It is underutilization of abilities, in the face of real needs and assigned authority, which disturbs members. As one member put it, "... it is important for the skills of the board members to be used and for authority and responsibility to be given to area boards to determine programs, their priorities, etc., which also means having an influence on area budgets and how these monies are spent."

The picture of how members' high level of expectations might have evolved, or of the origins of this ideal of the Area Boards, is becoming clearer. But, before proceeding to a summary review of the information elicited from these comments, we will quote one final statement which seems to sum up the feelings of many of the members:

"Many excellent people are wasting tremendous amounts of time and effort in attempting to work within an ill-conceived, ill-defined structure."

Conclusion

The members of Massachusetts Area Boards have high expectations about the role of their boards. They feel that they are capable of handling substantial power and responsibility and that, if it is not forthcoming, the boards are doomed to frustration and probable failure.

We have found that there is no way to explain this preference for a strong role for the boards by means of differences among members in terms of lack of knowledge about legal limitation, personal characteristics or experiences, or the model provided by significant reference groups. The concept of a strong role for the boards does not vary with length of membership on the boards; it seems to be the product of a basic attitude, or set of attitudes, deeply and broadly ingrained in members. It seems to result from some combination of attitudes concerning the appropriate balance between responsibilities assigned and powers granted, and a feeling that, if people are to exert themselves on civic tasks, the tasks should be structured to allow them to carry out those tasks to the extent of their abilities.

CHAPTER NINE

CONCLUSION

Citizen participation in government is an old tradition and practice in American democracy. It has been observed in a wide variety of institutions and settings from mass riots to presidential factfinding commissions. But in recent years, as noted in Chapters One and Two, new forms of citizen participation have evolved. Some of these are new in and of themselves, having new purposes or representing new interests, while others are new only in that their total environment has evolved drastically. Some are the result of indigenous citizen activities, while others have been initiated as a result of governmental actions.

The form of citizen participation that has been the focus for our efforts in this dissertation has been the Area Boards of the Massachusetts mental health and mental retardation system. These boards have been considered important institutions for Massachusetts and an example of quasi-governmental citizen boards in the early years of their development.

The particular topic addressed by this research effort has been the evaluations members of Area Boards make of the usefulness

and success potential of this form of citizen participation. We have been interested in the standards according to which the members make judgments about their boards.

One of the reasons for this research is the fact that, while there exist many published statements by social scientists, social planners, and political and bureaucratic activists about the criteria for evaluating citizen participation, we have few, if any, useful statements about citizen participants' own viewpoints on the matter. This is especially true in the case of quasi-governmental boards. More research has been carried out on participants in political organizations and activities than on specialized boards operating in the political netherland between open politics and the governmental bureaucracy. Thus, we saw a need for more direct, empirical knowledge of this particular set of citizen participants.

The practical implications of systematic knowledge of citizens' evaluation criteria are great. In designing institutions for citizen participation on the fringes of government, we are constantly faced with the need for solid information. Whether we are trying to strengthen citizen participation institutions, trying to get their support for governmental policies or choices, trying to understand them, we need to know the standards they are trying to achieve. Knowledge of citizen participants' criteria for self-evaluation is an important goal of modern social science.

In the pages ahead we will review the knowledge we have gained from the research effort described in the previous eight

chapters. We will try to show its relationship to our understanding of the Area Boards of the mental health and mental retardation system of Massachusetts. Next we will discuss the wider implications of our results for citizen participation in general, for role theory, and then relate our conclusions to the criteria schema presented in Chapter One. Finally, we will conclude with a few comments on future research needs in this area of citizen participation.

Summary of Overall Findings

The most important single finding of this research is the fact that members of Massachusetts Area Boards have an ideal of the role of their boards which apparently exists prior to their service on the boards and is unrelated to any of the matters of personal background, experience or circumstance which might be expected to influence that ideal. The members almost unanimously want their boards to play a strong role in the mental health system. The members are not swayed by knowing the more limited role protrayed in law or the more limited expectations set by other relevant groups in the system. There seems to be a conception of the proper role for a citizen advisory board which transcends all other factors.

There is only one possible source suggested for the formulation of this citizen ideal. It is the basic political socialization that pertains to the class of citizens who have chosen to accept nomination to Area Boards. We have concluded that, having eliminated other explanations, only a deeply ingrained socialization process

could account for the strength of the resulting ideal of citizen participation. The operation of this socialization process is almost entirely unknown to us. We lack data on the earlier years of Area Board members and must rely on inferences to identify the roots of the socialization to a strong ideal. However, we have uncovered members' comments which suggest a preoccupation with meaningful role definitions as a prerequisite for a high evaluation of participation. That is, several members suggested in different ways that the class of people belonging to Area Boards were accustomed to the exercise of power, and that they could see little use for participation if it were not designed to include the potential for power.

Even as we have learned that the elementary criteria for a successful evaluation of quasi-governmental citizen participation is the enactment of a strong role for citizens--one including the functions of oversight and policy-making--we have developed a number of lesser but nonetheless important conclusions:

(1) The evaluation of boards by members has declined.

Generally Area Board members joined their boards with a positive feeling about the potential usefulness and success of their board, as we saw in Chapter Three. A few expressed reservations about their boards, but for the most part members had high hopes.

Between the time that they joined their boards and the time the survey of their attitudes was made, many of the members' evaluations had become less favorable. According

to our evidence, they had compared their experiences with the role of their boards as they exist with the ideal they brought to the board, and had decided that boards were neither so useful nor likely to be so successful as they had thought. The members exhibited disillusionment with their experience of citizen participation and their opinion of Area Boards decreased.

(2) Objective achievements are irrelevant.

The Area Boards have established a strong record of association with successful accomplishments in mental health and retardation. They have successfully sponsored innovations in service and have successfully lobbied with the Department of Mental Health and the legislature. But these successes have not increased their evaluations of the boards. Board members seem to be less concerned with specific achievements than with the attainment of what they consider to be their proper role in the overall system.

(3) Role enactment is inadequate.

We have already commented on this essential point: Area Board members do not feel that the role enactment that has taken place is anywhere near the desired level. They perceive the discrepancy with their ideal and their evaluation declines.

(4) Role ambiguity is associated with unfavorable evaluations.

Members reported uncertainty concerning the role of the Area Boards to be extensive. It easily exceeded the uncertainty expressed in other responses, leading to the view that it is not uncertainty about the role of the boards, but uncertainty about the proper response to the failure of role enactment to match the members' role ideal, which is the problem.

(5) Role conflict is associated with decreasing evaluations.

Two different forms of role conflict, one associated with conflicting role expectations between members and relevant reference groups and one involving conflict between role enactment and the members' ideal, produced decreasing evaluations. Area Board members experiencing role conflicts were subject to a disillusionment and dissatisfaction with their boards.

The Implications of the Research Conclusions for Massachusetts Area Boards

The implications of the results of this research for the Area Boards of Massachusetts depend upon the interpreter's own evaluation of citizen participation in governmental service agencies. As in many cases, the new information gained from research can be used in many ways. But for our purposes here we will assume the intention is to support the further development of the boards. For the purpose of

drawing conclusions, we will assume that this kind of citizen participation is of at least potential benefit for mental health and retardation services; we are accepting the arguments offered by the authors of this Area Board system.[1]

From the first fact reported above, we know that members' evaluations of the Area Board approach to citizen participation have decreased as they have learned more about the roles of their boards. We know that their opinions of their boards are dropping. What effect does this have on the Area Boards?

All of the information we have derived about members' participation on boards suggests that members need a positive evaluation if they are to remain interested in attending meetings. Many of the more frustrated have commented directly on this point. Others have suggested it as an explanation for what they have reported to be a large number of resignations due to frustration and disillusionment. And we can also predict, from the argument above as well as from the basic motivation theories of psychology, that positive evaluations are necessary for the long-term success of any voluntary social institution--especially an institution without a substantial source of reward.

The most obvious solution to the problem of the Massachusetts Area Boards, given the desire of the interpreter to assist in the development of citizen participation on boards, is to rewrite the

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[1]The Medical Foundation, Inc., op. cit., chap. viii.

legislation and to grant more legal authority to the boards to conduct oversight functions and set policy for area programs. There would seem to be no shortcut to a reassessment of the legal role of the boards, bringing the law into closer relation with the members' ideal.

Although the revision of law is the most obvious, there are other possibilities. These methods do not stem directly from the research, but they are possible. One of these methods would be to recruit a new set of members representing different social groupings. We do not have evidence to show that other kinds of members share the citizens' ideal of the role for citizen boards. Another method would be through a strongly supported resocialization effort. But we might notice that the members' ideal is deeply ingrained and unlikely to be easily altered.

In summary, perhaps the most successful approach to reversing the evaluation trend among Area Board members in Massachusetts would be to rewrite the enabling legislation from a new point of view. The law would need to equate more carefully responsibilities and the power to carry out the responsibilities, and it would need to include a greatly strengthened role for the boards in the mental health and retardation system.

Broader Implication for Citizen Participation

The research described in this dissertation has an important and useful, if restricted, implication for citizen participation in

the United States. It suggests the existence of an elementary belief or set of attitudes about the role of citizen boards on the part of middle and upper class Americans, and the significance of that belief on the structuring of citizen boards. This research suggests that citizen boards being established in governmental service agencies and, most likely, in many modern settings must give early attention to the careful matching of citizen expectations and the legally defined role of such boards. When the gap between expectations and assigned role can be expected to be great, the dissatisfaction and disenchantment of members can be predicted. Citizen participants in government will not be happy when they are unable to balance the ideal they have of themselves as part of the governmental system with their assigned roles.

However, before this implication is fully accepted, two major limitations, in addition to the basic social class limitations inherent in the study, must be carefully noted. First, the Area Boards of Massachusetts have not done everything within their legal power to close the gap between their boards' actual roles and their ideals. We cannot be fully assured of the implication of the basic finding until this contradiction is resolved. Secondly, we have only assumed that devaluation of the usefulness and workability of the boards indicated some kind of failure for citizen participation. It does seem to be empirically true, from observations made of Massachusetts boards, but it is unproved. Other environments, or future times,

might cause other outcomes; dissatisfaction could lead to constructive rebellion and subsequent strenghening of the boards.

Implications for Role Theory

Although the primary theoretical purpose of this dissertation has rested with establishing citizen participants' criteria for evaluating citizen participation, we have paid a great deal of attention to Area Board roles and role theory. We have found role theory useful from a number of important standpoints. First of all, it has served as a means of creating continuity in formulations closely tied to the empirical base of the research effort. Secondly, it has helped to generate testable hypotheses for suggestions arising from that empirical base. Before we complete the overall review of this dissertation, we should take another look at role theory in our research.

Role theory became especially important when it became clear that the feelings of Area Board members were not focused on one or two aspects of Area Boards, but on many. We needed an organizing concept which would allow for many differing interests of members and still concentrate discussion and attention on basic issues. Thus, when it appeared that it would be legitimate to generalize role theory from it's more common application to individuals and apply it to groups of individuals, we were pleased. Role theory, then, became the centralizing force for the broader study of citizen participation evaluation criteria.

The hypothesis generating power of role theory was also important to this research in that two of our hypotheses came from research making use of role theory. These were the works by Riessman and by Gross. The other two hypotheses came from work using a pattern of thought quite conducive to role theory, these being the works of Caplow and Etzioni.

Altogether, role theory has been an important and useful framework for this analysis. There were times when the investigator was tempted to abandon this broad framework and concentrate instead on specific issues and problems. But this would have been to the overall detriment of the purposes of the research; it would have driven the research away from its strongly empirical base. That is, it would have abstracted too far from the citizen participants' viewpoints and outlooks.

It has not been a purpose of this research to contribute to role theory per se. But perhaps the results of the research can make a small contribution here. For we have successfully employed a concept usually applied at the individual level and made good use of it at the level of collectives. We have tested hypotheses about group roles and made reasonable interpretations based on the results. In short, role theory seems to be a useful tool for dealing with research focusing not just on the individual, but also on groups.

Members' Criteria in Perspective

Throughout this dissertation we have been seeking an empirically sound understanding of the criteria citizen members of

Area Boards use to evaluate their participation. We have been trying to determine, through tests of hypotheses derived from the citizens themselves and social science theories, just what factors are important in satisfying citizens about their difficult tasks. And, we believe, we have made some progress toward our goal.

Citizen participants of the kind we have found on Area Boards are firmly convinced that, to work and be useful, their boards must be substantial participants in the decision-making process of government. We have found that the members have an ideal conception of the role of their boards and that, if the actual role is divergent from that ideal, their evaluations of the boards drop. In other words, we have found that members' criteria for positive evaluations of their boards are based on the fulfillment in practice of a role growing not out of the law or out of the expectations of relevant groups, but out of the basic theory of the citizens.

Looking back at the models of criteria of evaluations developed in Chapter One, we see clearly that the citizen viewpoint falls totally into the Democratic-Theoretical model. We can describe citizen participation as "... a rightful process stemming from the people's right to be involved in the decisions of their government." The citizens on Massachusetts Area Boards agree: citizen participation is a basic, undeniable right, duty and responsibility growing out of the principles of American democratic theory. According to their viewpoint, the citizen boards are not in existence to be the

spokesmen for a special interest group, e.g., social change, but are an elementary and permanent part of American government.

The first and most obvious implication of this finding is that, to assist in the development of citizen boards, it is important to draft real powers and real participation into the role. It is only by approaching the idealized role conception of the members that their full cooperation and participation can be obtained.

Other implications can be drawn by various readers. If the reader agrees with the Democratic-Theoretical approach to government, he can be glad because the institutions he favors have the proper support and, if designed accordingly, will succeed. If the reader holds one of the other viewpoints, he will have some important knowledge to use in supporting or opposing the boards.

Implications for Further Research

The choice of topics for this dissertation was based on the feeling that there was a practical need for the investigation in terms of the future growth of the Area Boards. It was based on the belief that citizen participation is a contribution to community mental health at this point in time and an innovation worthy of support. However, there are other aspects of the question of citizen participation in community mental health which deserve consideration. Some of these are closely related to this piece of research; others are more general.

Already in this chapter we have referred twice to the need for further research on the failure of the Area Boards studied to implement fully the role granted to them. We would like to know why so many board members decreased their evaluations of their boards due to a gap between the actual and the ideal when they had strong motivation and the means to change the relevant circumstances. Is agency resistance to citizen participation at fault? Is there something about the structure of the citizen boards which makes them basically unsound?

Another topic closely associated with this one is the question of the ultimate value of citizen participation in community mental health. What impact does it have on mental health and retardation services? We know that the achievements assigned to the Area Boards are substantial; why are these not sufficient to justify the boards to the members? What, after all, is the role of Area Boards in community mental health? Why do we encourage citizen participation in governmental service agencies?

Final Conclusion

This investigator has found, after a fairly lengthy association with Massachusetts Area Boards, that the question of the role and function of the boards is still of great interest to him. He has found at least one answer, the main finding reported above, and many new possibilities. He has found that the topic of citizen participation is only beginning to unfold, and that there are more

uncertainties and unknowns in the topic area than certainties. But during the many hours of research and hours of subsequent professional contact the investigator has come to respect the principle and practice of Area Boards in mental health and retardation. This investigator hopes that further research will be conducted on Area Boards and on quasi-governmental citizen boards of all types, and that answers are found for the many questions that exist in this interesting area of civic activity.

APPENDIX A

RESPONDENT QUESTIONNAIRE

N.B. This is not the original format. It is here condensed for reproduction purposes.

This is not an administrative code number. It will not be used to identify you by name. Confidentiality is assured.

#_____

I. How certain are you about the role of Area Boards in mental health and retardation? Please check the appropriate box to express your agreement or disagreement with the following statements:

1. During my first few months as an Area Board member I felt rather uncertain about the role of the Boards.

2. I still feel rather uncertain about the role of Area Boards.

3. In particular, I am still unclear about:

   a. The general purposes of Area Boards.

   b. The duties and responsibilities of Area Boards.

   c. The power or authority of Area Boards.

   d. The proper relationship of Area Boards to the Central Department of Mental Health.

   e. The proper relationship of Area Boards to Regional Offices of the Department of Mental Health.

   f. The proper relationship of Area Boards to local mental health or retardation facilities (clinics, hospitals, etc.)

   g. The proper relationship of Area Boards to private mental health or retardation associations.

   h. The proper relationship of Area Boards to the citizens of the Area.

(Response categories are:

Agree strongly; Agree; Can't say; Disagree; Disagree strongly)

II. In this section we would appreciate your evaluation of what the current situation on your Board is and what it should be. Please supply two judgments.

4. It is a general purpose of my Area Board to:

   a. Increase public support for efforts to provide better mental health and retardation services.

   b. Learn and represent the views of Area citizens on issues of mental health and retardation services.

   c. Advise the Department of Mental Health as to what mental health and retardation services are needed in its Area.

   d. Make policy decisions on matters relating to the provision of mental health and retardation services in its Area.

   e. Oversee the provision of mental health and retardation services in its Area and raise its voice when it disapproves of activities observed.

5. It is a practice of my Area Board to:

   a. Sponsor programs to educate the public about the problems of mental health and retardation.

   b. Plan and initiate new mental health or retardation services.

   c. Approve or reject Area Plans presented.

   d. Allocate mental health and retardation funds within its Area.

(Response categories are:

What is:

Is; Uncertain; Is not

What should be:

Should be; Uncertain; Should not be)

III. Now we would appreciate your impressions of how other groups or individuals view your Board's proper role and what relations your Board has with these others.

6. How do you think the people listed below view the proper role of your Area Board? (Check as many as apply in each case.)

a. Staff of Central Department of Mental Health.

b. Staff of local mental health and retardation facilities.

c. Your Regional Administrator.

d. Your Area Director (or Acting or Associate Director).

e. Members of your local Mental Health Association.

f. Members of your local Association for Retarded Children.

g. The general public in Area.

(Response categories are:

Others see my Board's purposes as:

Public relations; Providing advice; Making policy decisions; Overseeing services; Don't know or can't say)

7. Which of the columns at the right best describe the relations between your Area Board and the groups or individuals listed below:

a. Central Department of Mental Health.

b. Your Regional Administrator.

c. Your Area Director (or Acting or Associate Director).

d. Local mental health or retardation facilities.

e. Your local Mental Health Association.

f. Your local Association for Retarded Children.

(Response categories are:

Relations are:

Close and supportive; Close but unsupportive; Distant but supportive; Distant and unsupportive; Don't know or can't say)

IV. We would like to know something about your experience in mental health and retardation, both before you became an Area Board member and since.

8. For approximately how long had you been associated with mental health and retardation work, prior to your Area Board membership?

_____ years

9. What was the nature of your involvement during this time?

Voluntary and occasional; Voluntary and continual; Professional; None.

10. How long have you been a member of your Area Board?

_____ Years _____ Months

11. How frequently do you attend your Area Board meetings?

Almost always; Regularly; Seldom; Have dropped out.

12. How active a role do you generally play in meetings?

Am a listener; Contribute to discussion; Contribute and frequently lead; Can't say.

13. Do other members of your Area Board seek you out for your opinion on matters related to the Board?

Yes, frequently; Yes, occasionally; No, not yet.

14. Do you hold any office or special position on your Area Board?

Yes, I am: _____; No.

15. Are you an official representative of a Mental Health or Mental Retardation Association on your Board?

Yes, a Mental Health Association; Yes, an Association for Retarded Children; No.

16. Please indicate the extent to which each of the following individuals or means were important in orienting you to your role as a member of your Area Board?

a. The pamphlet, <u>Your Area Board: A Trust and a Challenge</u>.

b. Your Acting Area Director or Associate Director.

c. Your Regional Administrator.

d. Fellow Board members who are laymen in mental health and retardation

e. Fellow Board members who are mental health or retardation professionals

f. Fellow Board members who are members of an Association for Retarded Children

g. Fellow Board members who are members of a Mental Health Association

h. Board President

i. Predecessor on Board

j. Citizens from Area who are not Board members

(Response categories are:

Very important; Important; Not very important; Not available to me; Don't know.)

17. a. Have you felt the need to seek additional information about the proper role and function of your Area Board?

Yes, frequently; Yes, occasionally; Yes, infrequently; No.

b. If yes, did you actually try to get more information?

Yes; No.

c. If yes, from which sources did you try to get further information? (Choose letters from question 16 above.)

d. Which, if any, of these provided you with information you found helpful?

18. a. Have you recommended or tried to initiate any new mental health or retardation programs or activities that could be sponsored by your Area Board?

Yes (How many); No.

b. If yes, were any of these programs successfully launched, or are any expected to be launched, as Area Board projects? (Check as many as apply.)

Yes, one or more fully launched; Yes, one or more partially underway; No.

19. What were your opinions on the following statements when you first joined your Area Board?

    a. Citizen boards are a useful addition to the mental health and retardation system.

    b. The Area Board form of citizen participation will certainly work.

    c. Citizen members have enough technical knowledge of mental health and retardation to serve effectively on Area Boards.

(Response categories are:

Agree strongly; Agree; Can't say; Disagree; Disagree strongly)

20. What is your opinion on these statements now?

    a. Citizen Boards are a useful addition to the mental health and retardation system.

    b. The Area Board form of citizen participation will certainly work.

    c. Citizen members have enough technical knowledge of mental health and retardation to serve effectively on Area Boards.

(Response categories are:

Agree strongly; Agree; Can't say; Disagree; Disagree strongly)

IV. Personal information (to be used for aggregate statistical analysis only).

21. What is your highest level of education and/or earned degrees?

22. What is your current occupation or profession?

23. What type of employment do you have?

    Self-employed; Housewife; Retired; Not employed; Local government; State government; Federal government; Public welfare organization; Private business; Religious organization; Private welfare organization; Other.

24. a. Are you, or have you been, a member of other civic business boards?

    Yes; No.

b. Please list any boards (aside from Area Boards) you have attended as a member. (By kind of board)

25. Have you been involved in civic activities before?

Yes, frequently; Yes, occasionally; No, not to speak of.

26. How long have you been a resident of the Area served by your Area Board?

27. What was your total family income, from all sources, before taxes in 1969?

0-5,000; 5,001-10,000; 10,001-15,000; 15,001-35,000; over 35,000.

28. Has there ever been any mental illness or retardation in your immediate family?

Yes; No.

29. What is your marital status?

Single; Married; Widowed; Separated; Divorced.

30. How many children do you have? Ages of children _____

31. In what year were you born?

32. What is your sex?

Male; Female.

33. We encourage, in the space below, any comments you have on Area Boards, or on your experience as an Area Board member.

APPENDIX B

PREPARATION OF THE BOARD ACCOMPLISHMENT MEASURES

1. Interviews with Area Board Presidents and Coding of Interview Schedules

   Data collection and preparation for this phase of the research included construction of interview schedules designed to:

   a. gather thorough information concerning Area Board acitivities, functioning, and accomplishments, problems and recommendations for change; and

   b. clarify and examine relevant issues for Area Boards.

2. Rationale for Selecting Variables for Further Analysis

   Our definition of accomplishment, which served as operational criteria for selection of interview items and construction of variables was any Area Board activity creating new mental health or retardation services or facilities, or improving the quality or increasing the quantity of existing mental health or mental retardation services or facilities, or substantially increasing public awareness of the need for mental health or retardation services or facilities, or having a high probability of doing any of the foregoing. Thus raising money for mental health or for mental retardation services or facilities counted as accomplishments, as did coordinating better the existing mental health or mental retardation services: but attendance of Area Board members at Area Board meetings, or the number of Area Board meetings held, were not counted as accomplishments in our sense, since the probability that they would accomplish any of the foregoing was not considered to be high enough.

   For a list of specific items, see Chapter Five.

3. Development of Measures of Board Accomplishment

The twenty-five variables chosen out of the Area Board presidents interview schedules were subjected to a factor analysis which produced our various measures of board accomplishment. We have made use of factor scores to develop categorical measures of the four factors produced by the analysis as well as two indices. These processes will be described in turn.

a. The Four Factors:

To develop an index of accomplishment the twenty-five variables from interviews with Area Board presidents were subjected to factor analysis. This analysis employed varimax rotations of Hotelling's principal axes structure. The percent of total common variance accounted for by the twenty-five "accomplishment items" was 47% as measured from the sums of squares. This solution was found to be stable over several subsequent iterations. The four-factor solution yielded four independent dimensions of accomplishment that appeared to be theoretically meaningful. The results of the factor analysis indicate that there are four independent types of Area Board accomplishment, that is, each type of accomplishment can be measured by a factor (cluster of items) statistically independent of the other factors. To represent each factor we chose those variables with high loadings on that factor and low loadings on the other three factors. A summary of the factors as reflected in the best representatives of each factor is as follows:

Factor I. Service Creation or Improvement (Service Factor)

This factor is best represented by two variables:

(1) The total number of services the board was involved in creating or improving, weighted for the degree of importance of the service (e.g., in the planning stage; nearing readiness for operation; in full operation).

(2) Average degree of involvement of the Area Board in service oriented activities, (i.e., does the board play a minor role, a major role, or is it solely responsible for the service), weighted for importance of the service.

Factor II. Mobilization of Outside Resources (Political Factor)

This factor is best represented by:

(1) Amount of money obtained by the board from the federal government.

(2) Amount of money obtained by the board from the state government.

(3) Frequency and extent of contact by the board with the Governor's Office for Administration and Finance. (This Office is roughly equivalent to the Bureau of the Budget in the federal structure.)

(4) Concertedness and persistent follow-through of Area Board attempts to gain support from the Governor, the Legislature, and the Commissioner of Mental Health.

Factor III. Local Autonomy (Local Factor)

This factor is best represented by:

(1) Amount of money raised by the board from within its area (including private contributions from within the area, local community tax funds, etc.).

(2) Tendency of Area Boards to review the budgets of health care institutions in its area (such as state mental hospitals in the area, local publicly or privately supported clinics, etc.).

(3) Action on annual plan for the area. (The greater the input of the board on the annual plan, and the greater its influence on the content of the plan, the higher the score here.)

(4) Area Board privately incorporated. (This was done by some boards to enable, within their area, to solicit, receive, and expend money locally, and contract locally on services, without having the expenditures subject to the approval of the state.)

Factor IV. Coordination (Contacts Factor)

This factor is best represented by:

The total number of contacts by Area Boards with service institutions (hospitals, clinics, schools, police, churches), weighted for kind of contact (i.e., ranging from mere informal communication to regular joint meetings, to collaborative action on a project). This factor describes the board's efforts to attain more extensive, efficient and fruitful collaboration with and among the social agencies and organizations serving its area (in order to extend or improve services). In a sense this represents an integrative effort by the board.

To facilitate analysis of these four factors we categorized the factor scores according to natural breaks in the data. The categories were labeled high, medium and low.

b. Factor Scores and Construction of Overall Measures of Accomplishment

From the items representing the four factors, two Overall Indexes of accomplishment were constructed. For Overall Accomplishment Index 1, the four factor scores were combined, weighted by the "sum of squares" (percent of total common variance accounted for) for its factor. For Overall Accomplishment Index 2, the factor scores were summed without weighting (i.e., were given equal weight). Once again, the data were separated at natural break points and divided into three categories.

APPENDIX C

INDEX CONSTRUCTION AND MEMBERS' RESPONSES

1. Members' Evaluations

The two dependent measures used in this study, changes in members' opinions about the usefulness and workability of Area Boards, were constructed similarly. A mathematical function compared responses which recall how members felt when they joined their board and compared them with how the same members felt at the time of the questionnaire, and results were categorized into three groups according to natural breaks in the frequencies. (For the questions and original response categories, see Questions 19 and 20 in Appendix A.) The function and categorization is as follows:

Function: Initial response - later response + 5 = a number from 1-9

Categorization: 1-5 = No Change; 6 = Some Change; 7-9 = Much Change

2. Role Conflict

Indices of role conflict between board members and the members' perceptions of the viewpoint of the Department of Mental Health were constructed by comparing responses from questionnaire questions 4c, d, e, and 6a. The specific questions were on the three functions of <u>advice</u>, <u>policy-making</u> and <u>oversight</u>. Comparisons of the two sets of questions for each function recorded only cases where the members' ideal of the role of their board <u>were</u> or <u>were not</u> in direct conflict. That is, if a member said he thought the boards should have policy-making powers but was not sure about the Department's view, the index recorded a blank for the comparison.

3. Conflict of Actual and Ideal

The indices used for these measures were prepared as those in Number 2 above. However, all of the comparisons came from the two separate parts of the series of questions under Number 4 in the questionnaire.

APPENDIX D

FREQUENCY DISTRIBUTIONS ON PERSONAL CHARACTERISTICS AND MEMBERSHIP EXPERIENCES OF BOARD MEMBERS

1. Age

	Frequency	Percentage
20's	8	2
30's	58	14
40's	137	34
50's	128	31
60's	63	15
70's	15	4
	N=409	100

SD = 1.086
Blanks = 31

2. Sex

	Frequency	Percentage
Male	270	64
Female	152	36
	N=422	100

SD = .481
Blanks = 18

3. Education

	Frequency	Percentage
H.S. or less	49	11
Some College M.A. Degree	273	64
Professional Degree	106	25
	N=428	100

SD = .588
Blanks = 12

4. Income

	Frequency	Percentage
Under 5,000	14	4
5 - 10,000	48	12
10 - 15,000	100	25
15 - 35,000	175	44
Over 35,000	63	16
	N=400	100

SD = 1.007
Blanks = 40

5. Length of Residence in Catchment Area

	Frequency	Percentage
5 yrs. or less	43	10
More than 5 yrs.	379	90
	N=422	100

SD = .303
Blanks = 18

6. Experience of Having Mental Illness or Mental Retardation in the Immediate Family

	Frequency	Percentage
Yes	148	35
No	269	65
	N=417	100

SD = .479
Blanks = 23

7. Experiences of Board Members Prior to Membership on Their Area Boards

a. Frequency of Participation in Previous Civic Activities

	Frequency	Percentage
None	30	7
Occasional	109	25
Frequent	291	68
	N=430	100

SD = .616
Blanks = 10

b. Membership on Other Public or Private Boards

	Frequency	Percentage
No	49	11
Yes	380	89
	N=429	100

SD = .318
Blanks = 11

c. Length of Previous Experience in Mental Health or Retardation

	Frequency	Percentage
None	61	14
Under 3 yrs.	47	11
3-9 yrs.	159	37
Over 9 yrs.	161	38
	N=428	100

SD = 1.029
Blanks = 12

d. Representative of MH or MR Associations

	Frequency	Percentage
No	255	59
Yes, ARC	92	21
Yes, MHA	84	19
	N=431	100

SD = .794
Blanks = 9

8. Experiences of Members on Their Area Boards

a. Length of Membership

	Frequency	Percentage
1st Yr.	52	12
2nd Yr.	68	16
3rd Yr. or more	308	72
	N=428	100

SD = .696
Blanks = 12

b. Level of Activity on Board

	Frequency	Percentage
Listener	53	12
Contributor	246	58
Contributor and Leader	131	30
	N=430	100

SD = .640
Blanks = 10

c. Holding Office

	Frequency	Percentage
No	201	47
Committee Member	110	25
Officer	121	28
	N=432	100

SD = .844
Blanks = 8

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