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## Citizen Participation within Mental Health Planning and Advisory Councils

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# **CITIZEN PARTICIPATION WITHIN MENTAL HEALTH PLANNING AND ADVISORY COUNCILS**

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### **Abstract**

This dissertation studies citizen participation, mental health care and block grants. Each state has a Mental Health Planning and Advisory Council (MHPAC) that is required by the Community Mental Health Services Block Grant program. Councils must consist of at least 50 percent citizens. This dissertation looked at MHPAC activity levels of the 50 states (and Washington, DC) and developed an activity level index to measure council activity from 2008-2011. Two main questions were posed. First, do planning council differ in their level of activity? If so, what explains this variation? Second, do differences in activity levels of MHPAC's explain variations in mental health outcomes? Additionally, four National Outcome Measures (NOMs) were analyzed to see if a relationship existed between these outcome measures and council activity levels. Three levels of analyses were conducted that included a Logit regression, an Analysis of Variance (ANOVA) and a linear regression analysis. The Logit regression showed that differences in activity levels do exist. Unfortunately, the results indicated that only one variable (state ideology) was significant; thus while states do differ in their level of activity; none of the hypotheses could conclude why activity levels differ. The ANOVA indicated that higher activity levels were associated with higher homeless rates. A poisson regression indicated that the model was significant and that higher activity levels were associated with lower numbers of evidenced based practices being implemented. The linear regression indicated that high council activity levels were significant and did play a role in mental health outcomes for three of the four NOMs studied. Overall, each NOM model was significant.

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## Chapter 1

Public health promotion is a main function of government in the United States and looks to eliminate or reduce illness. This public health model is a continuation of the normative assumption of what a government should do in the area of health care. Public health focuses on traditional areas of diagnosis, treatment, and etiology; health promotion, disease prevention, and access to and evaluation of services (Last & Wallace, 1992). An important piece of overall health care is mental health. Mental health care policy is similar to primary health care in that there are variations in quality, use of services, costs and many gaps in the safety net.

There have been several national level commissions and reports seeking to define and offer solutions to mental health care needs in the United States. The first was congressional called the Joint Commission on Mental Illness and Health (1955) which published a report titled Action for Mental Health (1961). This report highlighted the nationwide problems of the mental health system and lead to the release of thousands of the chronically mentally ill to community settings from state asylums with the passage of the Mental Retardation Facilities and Community Mental Health Centers Construction Act (1963). The second commission was initiated by President Carter (1977) and called the President's Commission on Mental Health. With this report the national policy focus shifted toward mental health and away from mental illness, using the public health model. The report resulted in approval of the Mental Health Systems Act of 1980 by President Carter. However, the election of President Reagan and the passage of The Omnibus Budget Reconciliation Act of 1981 returned most of the direct

responsibility for mental health care back to the states with federal assistance coming through the grant-in-aid system by the use of block grants.

To highlight the plight of the mental health system as an important public health concern in the United States, the Surgeon General released a report in 1999. This report described the fragmented mental health system in which people who needed treatment were not served. This landmark report provided an overview of prevalence rates and descriptions of mental illness. It also advocated increased research, state of the art treatment and increased access to quality services. The Surgeon General's Report was closely followed by another presidential commission called The New Freedom Commission in 2001. This commission released a report (2003) highlighting a host of problems with the mental health care system in the United States. Two reoccurring issues were cited. First, the United States does not have a national mental health care policy, so each state has its own. This arrangement is positive for states because they can adapt their programs to the unique conditions in their state, but has the disadvantage of creating disparities in services amongst the states. Mental health is singled out more than any other public health or medical discipline by the federal government for exclusion and discrimination because it considered the principal domain of the states (Urff, 2004). Second, fragmentation of services and the management of sometimes difficult relations between all levels of government, public and private spheres add to the problem (Brown and Stockdill, 1972: 678-680) and lead to a host of unmet mental health needs.

## Block Grants

The federal government attempts to influence mental health policy at the state level through the grant-in-aid system to assist meeting unmet needs. The federal grant-in-aid system can be defined as the giving of federal funds to a state or local government to subsidize conditional public projects. These conditions permit the federal government to direct state and local policies as a requirement to receive funding. Block grants are used for broad functional areas, are based upon a statutory formula and allows for significant recipient latitude in utilization (Advisory Commission Intergovernmental Relations, 1994). In fact, the federal government expected to provide state and local governments \$584.3 billion in grant-in-aid funding during FY2012 (pewtrust.org, 2011).

The federal government utilizes the Community Mental Health Services Block Grant (CMHBG) to influence state level mental health policy. This grant mandates citizen participation and the formulation of a Mental Health Advisory and Planning Council (MHPAC) in each state (and U.S. territory) to help reduce discrepancies in mental health care. This research will look to answer two fundamental questions. First, is there variation in activity levels by Mental Health Planning and Advisory Councils? If so, what might explain these variations across the fifty states (& Washington, DC)? Secondly, do differences in council activity levels explain variations in mental health outcomes?

The CMHBG is the largest discretionary block grant for mental health in the United States. This block grant is part of the federal government's grant-in-aid system that attempts to implement a collaborative public health model for mental health. The federal government

places certain structural requirements upon states, but allows states a large amount of flexibility to address local mental health needs.

Each state is required by the CMHBG to submit a state plan and implementation report every two years (annually up to 2012) to the Center of Mental Health Services within the federal Substance Abuse and Mental Health Services (SAMHSA) of the Department of Health and Human Services. The state plans evaluate both the adult and child mental health system in each state (and U. S. territory). The state plan is broken down into sections that include an overall review of the state mental health system, new developments and issues, recent legislative changes and a description of the mental health agency leadership for both the child and adult systems. The state plan goes on to highlight the system's strengths, unmet needs, priorities and vision for the future for each state system. The implementation report has similar structure, but is focused upon how well the individual state is progressing (or not), along with their respective state plan's goals or performance indicators (SAMHSA.gov, 2011).

The performance indicators for the CMHBG are an attempt by the federal government (SAMHSA) to standardize certain measurements of mental health on a state level. The states have much leeway surrounding which performance indicators they choose to utilize, which results in great difficulty in comparing data amongst individual states. The resulting performance indicators are sent to SAMHSA and compiled across ten outcome domains called the National Outcome Measures (NOMS). These NOMS are compiled and reported annually to the federal government. The byproduct of this data analysis is a compilation of various outcome measures for each state (and U.S. territory) called the Uniform Reporting System

(URS) Output Tables. These outcome measures are used by the federal government to measure national and state progress for the established NOMS.

An additional mandate in the block grant is the requirement that each state create a MHPAC. This council is required to advocate, evaluate and monitor the mental health system in each state. The composition of this advisory council is to be made up of at least 50 percent private citizens, ex survivors, or consumers of the mental health system, and 50 percent state employees representing the various departments that are important to mental health within each state (and U.S. territory). Examples of state department involvement include social services, Medicaid, welfare, criminal justice, education and mental health. The MHPAC must submit a letter to the state mental health administrator of each state (and U.S. territory) that provides an overview of the state plan for submission to the federal Center of Mental Health Services (CMHS) division of SAMHSA. The same is true for the implementation report; an annual implementation letter is submitted along with the implementation report. In sum, the MHPAC as authorized by the Community Mental Health Services Block Grant provides for citizen participation.

#### Normative Questions and Citizen Participation

Citizen participation in government is an essential part of our democracy and took on new meaning beginning in the 1960s. This new era of citizen participation came during the civil rights movement (and Vietnam War) and was in response to citizen skepticism concerning public policies. The social unrest led to a major expansion of federal government programs in housing, education, environmental protection and mental health to name a few. The grant-in-

aid system was one mechanism utilized to address this broader role by the federal government in public policy.

Demands for increased citizen participation are tied to the normative questions related to the proper role of citizens in a democracy. A democracy is a form of government in which... “power and civic responsibility are exercised by all citizens, directly or through their freely elected representatives (America.gov, 2008).” Democracy is governed by a core set of principles that include majority rule, protection of minority rights, free periodic elections and a decentralized government where citizens have access to government processes, particularly at the local level. Stewart (2007) writes that there are two categories of authors who write about normative based studies within a democracy. Those that think “increased citizen control over the policy process is a social ‘good,’ and those who think that state officials are best qualified to make decisions for the community (p. 1068).” Arnstein’s (1969) “A Ladder of Citizen Participation” supports the first notion surrounding citizen participation as a public good based upon the type of participation and the amount of control offered to citizens. The normative assumption is that low income and ethnic minorities should have more control over public policies that affect them. Fiorino (1990) states that participation should begin with a normative argument that citizens can best judge their interests. Other authors line up on the other side of the normative argument, citing that state officials are the most capable of making sound public policy. Walters, Aydelotte and Miller (2000) assert that state officials are most proficient at making policy decisions, while acknowledging that public input has a place in the policy process. This assertion is grounded in the belief within the Federalist Papers of limited government (James Madison) with government decision making removed from the direct influence of public

passions. Furthermore, those who argue against citizen participation point to the fact that governments face complex and technical questions that the layperson may not understand. The normative argument that citizen participation in a democracy is necessary to promote what “should” happen in government in the areas of fairness, equity, transparency and representativeness regarding the public good is not the focus of this research. As previously indicated, the current research is focused on citizen participation on mental health planning councils and whether these councils make a substantive difference in mental health policy outcomes.

Citizen participation can take many forms and refers to purposeful activities in which citizens take part in relation to government (Langton, 1978, p. 17).” In general, most authors agree that citizen participation involves citizens attending some government function and attempting to influence decisions. The level of impact into decisions is usually one of the main questions to be answered. Citizen participation has been defined by others as providing citizens with opportunities to take part in government decision making (Glass, 1979). Participation is often used in almost any situation in which even minimal interaction occurs, having little influence and simply being educated about a decision that has been made (Pateman, 1970). Gamble & Weil (1995) believe that citizen participation is the active, voluntary involvement of individuals to change problematic conditions and influence policies.

The 1979 study on citizen participation by the Advisory Commission on Intergovernmental Relations (ACIR) highlighted thirty one different forms of participation. All these forms can be further consolidated into four broad types that include organizational,



individual, dissemination of information and information collection. Organizational forms of citizen participation are citizen advisory groups, special interest groups and official citizen committees. Voting, being a program client, working in public projects, lobbying and demonstrating are some examples of individual forms of participation. Dissemination of information occurs in the mass media, the mail, presentations at conferences and open government initiatives. Information collection occurs in public hearings by politicians, consultations, in government records and surveys. The public administrator has the task of deciding how much influence or control the public will have over decisions, which citizens to involve and the specific form of citizen participation to be employed. In sum, citizen participation approaches can range from one way communication on one end, to dialogue shared and processed by multiple participants at the other (Lukensmeyer and Torres, 2006).

### Congressional Acts

Two important pieces of legislation cited in the literature on citizen participation are the Economic Opportunity Act of 1964 and the Demonstration Cities and Development Act of 1966. These two pieces of legislation called for mandated citizen participation in government decision making and formed the basis for federal involvement public policy via the grant-in-aid system. A number of arguments emerged in response to the realization that citizens were not actively participating in government decisions (Cooper, Bryer, and Meek, 2006). The Economic Opportunity Act of 1964 and the Demonstration Cities and Development Act of 1966 called for “maximum feasible participation” to provide greater input for poor and disenfranchised people into the policy making process. These acts were important in many different policy areas,

including mental health, because it was the first time that the federal government mandated citizen participation. The Economic Opportunity Act of 1964 legislated for the “maximum feasible participation” of the poor in government programs and was a part of President Lyndon Johnson’s broader War on Poverty program. Central to this program was an understanding that poverty’s complex and multi-layered causes would require the “maximum feasible participation” of affected communities. This Act authorized a defined role for citizens in deciding expenditures, the design and execution of significant programs. This new direct democracy role met vigorous resistance by city governments, as citizen needs were seen to compromise the rational allocation of resources. Requirements for citizen participation were generally viewed as a cost of doing business instead of an asset to effectiveness or a responsibility worth carrying out for its own sake (Jones, 1981; Mladenka, 1981; Thomas, 1995).

The Demonstration Cities and Metropolitan Development Act of 1966 (or The Model Cities program) saw citizen participation expectations lessened and more control given back to city administrators who took on a more comprehensive approach to urban problems. The program called for a locally developed plan to eliminate obstacles that prevent residents of slums from obtaining such things as good jobs and adequate housing. This representative democracy type of act envisioned “citizen participation filtered through local government” and rejected the direct democracy model of the 1964 Economic Opportunity Act (Jackson, p. 10, 2008). However, these Acts did not lead to an increased role in real decision making envisioned by Congress.

Less discussed is the Mental Retardation Facilities and Community Mental Health Centers Construction Act (CMHC) of 1963 and its provisions for citizen participation in mental health. This Act (Public Law 88-164) and subsequent amendments provided the first direct federal involvement into mental health in more than one hundred years. The goal was to create a full and coordinated range of community based services available to all in need. Prevention of mental illness and promotion of mental health was a priority for the first time by the federal government. The citizen participation requirements were implemented slowly and resulted in Public Law 94-63 of 1975. This law mandated citizen involvement on “representative governing or advisory bodies” and began reviewing local Community Mental Health Center evaluation efforts. Change continued to be delayed because this new federal mandate demanded a new structure be created, had a lack of effective strategies to implement this new structure and board members did not understand how citizen involvement could improve services. CMHC boards saw themselves as representatives of the community (not citizens) and neither board member or non-board member citizens felt like they had the time to invest in this task (Dowell & Ciarlo, 1989).

This research examines planning council (MHPAC) activity levels for each of the fifty states (and District of Columbia) over a four year period (2008 – 2012). The activity level data will come from state plan and implementation reports that are submitted to SAMHSA as part of the Community Mental Health Block Grant. As mentioned previously, this research will look at two main questions. First, is there variation in Mental Health Planning and Advisory Council activity levels the fifty states? If so, what explains the variation? Secondly, if they are fully functional; do different levels of participation lead to different mental health outcomes?

Additionally, this research created an index to measure activity levels of the planning councils, measure the different types of activities the councils engage in, look at the composition of the planning councils and examine the frequency of those activities. This research will look to utilize outcome data from the SAMHSA's Uniform Reporting System as control variables to glean citizen participation influence on state mental health policy.

Citizen participation is important in a democracy. One area that shows a gap in the literature pertains to citizen participation within mental health planning councils. Highlighting the normative issues of citizen participation, the various types of citizen participation, providing a brief discussion of maximum feasible participation and looking at the reasons why mental health policy is important has provided an important rationale for this research. This research is particularly interested in the CMHBG and the role of the planning council activity levels on state mental health policy. This research will look at the nature of the Mental Health Planning Councils in all 50 states (and Washington, DC) to seek to understand the differences in council activity levels and whether they substantively participate in mental health care policy.

## Chapter 2

Citizen participation in government has long been a tradition in the United States, but has primarily been limited to voting. The founding fathers of the United States envisioned an indirect, representative form of government. Since the 1960s, the federal government has dramatically encouraged increased citizen participation. The civil rights movement, the Vietnam War and the Watergate investigations caused increased pressure from a populace that had become distrustful of government. Under the auspices of “maximum feasible participation” the federal government attempted to address this discontent by expanding citizen participation requirements. The federal government mandated citizen participation as a condition for receiving grant funding during the decision making process for state and local governments. There is little consensus about the exact origins of the term ‘Maximum Feasible Participation’ by the members of the Administrative Task Force or congressional drafters of the Economic Opportunity Act of 1964. However, MFP had become a powerful idea that had increasingly been circulating through the literature, amongst non-profit advocates and the U.S. foreign development assistance community in the late 1950s (Melish, 2010). This requirement has influenced all levels of government in the U.S. and most domestic policy areas. Citizen participation is rooted in the normative question as to what a government “should” do and what the proper roles of citizens are in a democracy. This form of intergovernmental relations between the federal, state and local governments is an important part of any federal policy discussion. This research will look at one way that the federal government influences policy on the state level by utilizing the grant in aid system. This chapter focuses on citizen participation in general, the Community Mental Health Block Grant in particular, the mandated requirements

for citizen participation within it and Mental Health Planning and Advisory Councils that are charged with implementing the citizen participation requirements.

### Normative Questions

The question of citizen involvement in a democracy raises the question of “should” a government promote or initiate this process. There are two trains of thought regarding normative based studies of citizen participation within a democracy. These trains of thought can be categorized as being either normative or instrumental arguments. Normative arguments are based on the idea that building citizenship and community is important for its own sake. Additionally, it is a right and leads to a healthier democratic society (Holmes, 2010). Instrumental arguments are aimed at the approval or implementation of a particular policy or project. From a normative perspective, government should facilitate citizen engagement because it is the “right” thing to do according to democratic ideals and can promote a sense of community. Community is defined by the social connections of people who feel that they have some common characteristics and who care about the common good. The case can be made in support of the norm of citizen participation due to past injustices and discrimination. During the last decade of the 19th century, a number of southern states held constitutional conventions to permanently disfranchise African Americans (CRS, 2008). For instance, the poll tax was implemented to discriminate or limit the voting rights of African Americans from 1871 to 1966. The high level of poverty amongst many blacks effectively disenfranchised many of them, as well as lower class whites. The first poll tax was passed by the state of Georgia in 1871. Kousser (1974) estimated that the Georgia poll tax probably decreased overall voter

turnout between 16 – 28 percent and black turnout in half. The literacy requirement was another tactic used by southern states to discriminate against blacks and poor whites. An individual was required to recite and write down subjective oral and written tests prior to casting a vote. Additionally, many southern states required a registered voter to vouch for someone seeking to register; an event that rarely ever occurred for a black voter by a registered white voter due to the fear of being ostracized.

The instrumental perspective looks to increase citizen involvement because local governments cannot solve community problems alone. Effective governance at the local level increasingly requires active and ongoing citizen participation in planning, policymaking, implementation, and service delivery. Citizens often have information that officials need in programs that are being designed. Moreover, citizens expect an opportunity to participate or they may resist in the implementation. Successful policy can be defined as one that is approved, implemented and where conflict is minimized or citizens cooperate with government initiatives (Svara and Denhardt, 2010). In essence, the problems facing local governments demand citizen involvement, acceptance and likely cooperation.

#### History of Intergovernmental Relations

Another important factor relating to citizen participation is the intergovernmental system of the United States. The very structure of the U S political system is an often overlooked, but significant, factor in shaping policy. This is not to say that policy is defined by structure. However, structure can transform priorities and reshape policy content in important ways. For example, substantial changes in mental health care policy often created incentives to

shift responsibilities to other levels of government. These shifts resulted in distortions to coverage patterns; unintentionally altering costs and goals (Grob, 1994).

Federalism can be defined as a system of authority constitutionally allocated between central and regional governments. Intergovernmental relations pertain to how the national and varied sub national governments interact towards each other. The idea of dual federalism, whereby there are two levels of government operating independently with an ambiguous overlap of responsibilities has been one perspective of the U S system from its' inception. Dual federalism implies separate and exclusive spheres of authority (Young, 2012). However, federal and state governments have never been completely independent of each other. For example, land grants, joint stock companies and various forms of technical assistance are examples of the federal and state reliance on each other prior to the twentieth century (O'Toole, 2007).

The twentieth century saw federal influence increase with the financial involvement of intergovernmental relations. The Progressive Era of the 1900s expanded the role for government in general. Reformers argued that the economy could not endure a laissez faire (passive) type government. The power of large corporations, the reluctance of some state governments to act, the growing bureaucracy and the observation of limited U S natural resources called for an expanded role for the federal government. By 1920, there were eleven grants-in-aid programs operating in the U S. The New Deal policies of the 1930s, in response to the Great Depression, permanently increased the density and importance of intergovernmental relationships. The grant-in-aid became the most common example of intergovernmental cooperation. A grant-in-aid is a transfer of funds from one government to another with conditions attached. Efforts to reduce interdependency have proved much more difficult than



theorized and often lead to unintended negative consequences (O'Toole, 2007). The number of federal grant-in-aid programs tripled between the beginning of the 1960s and 1975.

The vast expansion of grants allowed sub national governments to shop around for the best deal and the interagency competition for clients resulted in lax enforcement. The multi layered administrative functions caused decisions to be made outside the direct influence of state level officials because it was difficult to decipher who was causing what to occur. For example, the expansion of specialists across all levels of government (particularly administrative), having legislative committees charged with a specific areas and outside interest groups caused influence dispersal. This diffusion left governors, mayors and other major officials on the periphery of the decision making process. The result is a system composed of interdependence and complexity. Interdependence means that power is shared among branches and layers of government. Complexity means that the network is large, differentiated and no one participant can possess enough information to make a rational decision on their own. The intergovernmental system, being based upon interdependence and complexity, has led to bargaining under conditions of partial conflict among the different actors. These actors have different interests and cannot act alone, so they may join together into a loose coalition to achieve some intergovernmental objective (Anton, 1989).

#### History of Grant-in-Aid System

The federal government influences state and local government's inclusion of citizen participation by way of the grant-in-aid system. The grant-in-aid system is the federal system of grants to state and local governments with certain conditions attached. This allows the federal government to guide or influence public policy on a sub national level. The grant-in-aid system

has changed dramatically over the years and predated the United States Constitution. Grants of land under the Articles of Confederation began as far back as 1785, when the national government would grant land to states for purposes of education. The Northwest Ordinance of 1787 lent additional support for this concept, as this was the first act in which the federal government utilized its resources to encourage the states to follow a national policy. Certain conditions existed during the 18<sup>th</sup> and 19<sup>th</sup> centuries that limited federal aid to states. Proponents of states' rights and a non-activist federal government prevailed during this time period. The post-Civil War period was an era of corporate dominance and weak national government. The federal government did provide aid to states (when necessary) to address such things as natural disasters, civil disturbances and westward expansion after the Civil War (Canada, 2003). However, the grants-in-aid system began to take its current form in the early 20th century. Financial grants created during the 1910s included grant mechanisms such as matching requirements and conditions, which are now common in grant programs. In the 1930s, President Franklin Roosevelt's Administration worked with Congress to accelerate the grants-in-aid system as part of the New Deal program. The Federal Emergency Relief Act of 1933 was the first direct grant to the states for public relief. The main goal was to alleviate unemployment by creating new unskilled jobs in local and state government. This act provided three billion dollars in direct relief to the states and provided 20 million jobs. This expansion was one response to the Great Depression and signaled the beginning of the modern grant-in-aid system.

The grant-in-aid system expanded significantly during President Lyndon Johnson's Great Society initiative of the 1960s. The citizen participation requirements began to dominate at this

time. The Nixon Administration worked with Congress in the 1970s; emphasizing block grants, general revenue sharing and programs that distributed funds to state and local governments without programmatic requirements. The Reagan Administration of the 1980s consolidated dozens of categorical grants into broader block grants and slowed the growth of the number of grants in the grants-in-aid system, but not the total amount of money spent on each program. While the grants were cut, the citizen participation requirements were actually expanded in the Mental Health Planning Act of 1986. This Act mandated that Mental Health Planning Councils be formed to provide comprehensive mental health planning within each state. Since the Reagan initiatives, there have been few significant design changes in the current grants-in-aid system.

#### Types of Citizen Participation

What exactly do we mean by citizen participation and what does it look like? Langton (1978) settles on a broad definition of citizen participation. Citizen participation refers to... “purposeful activities in which citizens take part in relation to government (Langton, p. 17).” In general, most authors agree that citizen participation involves citizens attending some government function and attempting to influence decisions. The level of impact into decisions is usually one of the main questions to be answered. Citizen participation has been defined by others as providing citizens with opportunities to take part in government decision making (Glass, 1979), participation is used in almost any situation where minimal interaction occurs, having little influence in decisions and can be as simple as being educated about a decision that has already been made (Pateman, 1970). Gamble and Weil (1995) define citizen participation

as the active, voluntary involvement of individuals to change problematic conditions and influence policies.

Two general categories can be utilized to describe the forms of citizen participation available: extra-electoral and electoral mechanisms. Extra-electoral citizen participation refers to processes by which citizens are included in policy making between elections (Dahl, 1956). Authors vary on the number of extra-electoral participation mechanisms from eleven mechanisms by Walters, Aydelotte, and Miller (2000), to thirteen by Bishop and Davis (2002) and twenty five by Rowe and Frewer (2005). Examples of extra-electoral participation include focus groups, citizen advisory boards, surveys, newsletters and referendums to name a few. Electoral mechanisms have to do with acts related to the election of public officials. These two forms of participation can be further categorized into four broad categories that include: organizational forms, individual forms, forms of information dissemination and forms of information collection. These four forms of citizen participation can be broken down even further into direct or indirect citizen involvement. Organizational forms of citizen participation are citizen groups, special interest groups and official citizen committees. Voting, being a program client, working in public projects, lobbying and demonstrating are some examples of individual forms of participation. Dissemination of information occurs in the mass media, the mail, shows up at conferences and in open government initiatives. Information collection occurs in public hearings by politicians, when consulting, government records and surveys. In sum, citizen participation approaches can range from one way communication on one end, to dialogue shared and processed by multiple participants at the other (Lukensmeyer and Torres, 2006).

The 1979 study on citizen participation by the Advisory Commission on Intergovernmental Relations (ACIR) highlighted thirty one different forms of participation and that “few people can object to the goal of involving citizens in intergovernmental decision making (ACIR, 1979).” All forms of citizen participation highlighted in the ACIR report attempted to meet at least one of the following objectives: giving information to citizens, getting information from or about citizens, improving public decisions or services, enhancing public acceptance of decisions, protecting minority and individual rights and delaying or avoiding difficult public decisions. The ACIR committee found that citizen participation requirements were contained in 155 separate federal grant-in-aid programs, almost one third of the total or eighty percent of the funding at that time. The most common membership mandate was the establishment of committees or boards with a directive surrounding membership composition. Citizen impact on policy varied from influencing priority setting in some programs and being merely a “rubber stamp” for administration in others. The major participants were the middle class, despite the goal of including lower income citizens in many grant programs. The ACIR concluded that citizen participation impact varied, but was generally modest (ACIR, 1979).

### Support for Citizen Participation

Supporters for citizen participation include Arnstein’s (1969) “A Ladder of Citizen Participation,” which shaped much of the discussion of participatory processes. Arnstein looked at citizen participation as a public good based upon the type of participation and the amount of decision making control offered to citizens. Its main effort is to replace top-down or

technocratic approaches to planning. The normative assumption is that low income and ethnic minorities should have more input over public policy making. Arnstein (1969) described eight steps on a ladder of citizen participation. The lower rungs of manipulation, therapy and informing are essentially non participatory or educational. Lower rungs were viewed as a one way flow of information from administrator to citizen, where the citizen has no real power to change policy. Arnstein indicates that advisory boards are usually a form of tokenism in which residents are consulted by public administrators about policy issues, but have no real control over the decision making process. The middle rungs of consultation and placation are just a facade for administrator decision making. The power to make decisions is retained by the public administrator. The higher rungs of Arnstein's ladder are partnership, delegated power and citizen control start to give citizens power on a continuum from shared to ultimate decision making authority. Viewed another way, citizen participation can be seen as either "bottom up" or "top down." Bottom up citizen participation sees citizens initiating and controlling policy activities. Top down participation is where government initiates and controls the activities. Arnstein (1969) and Gittell (1980) viewed the top down approach as neither yielding true benefits nor redistributing true power to citizens. Arnstein's model describes degrees of citizen empowerment corresponding with varying levels of involvement, but does not offer suggestions for evaluating the performance at any particular level.

Some observers take the position that participation should be expanded by government in all significant decisions and that citizens should be given the opportunity to work with public officials in a facilitative rather than a controlling role (Arnstein 1972; Box 1998). Another argument for increased citizen participation is based on the belief that administrators should

distinguish the kind of participation that is most appropriate based on information needs, level of acceptance and participation required by citizens to make the decision work (Thomas 1993, 2007). Thomas (1995) talked of the benefits that come from increased citizen participation that include improved decision quality, fewer mistakes, increased public acceptance, quicker implementation, more efficient services, increased citizen understanding and decreased criticism of the resulting policy. King, Feltey and Susel (1998) argue for an “authentic” citizen participation process whereby the process is more meaningful for all involved parties.

Authentic participation places citizens ahead of technical or administrative processes. Kweit & Kweit (1980) criticize participation efforts that lack authority, have no binding impact and have participation by a select few elitists, as flawed, because the general public was outside the process. Kathlene and Martin (1991) advocate for the use of long standing context specific citizen panel because most citizen participation techniques have proven to be less-than-adequate tools for informing policy makers about the people’s will (Gittell, 1980; Kweit and Kweit, 1981; Falkson, 1974; Strange, 1972). Several authors describe the important social functions of citizen participation (Cohen, 1995, Shearer, 1984). Additionally, Cohen’s work explored the need for participants to achieve a certain level of knowledge via paid professional technical assistance, so that they can make informed decisions.

### Opposition to Citizen Participation

There are authors that line up on the other side of the normative argument, claiming that state officials are the most capable of making sound public policy (Stewart, 2007). These

authors believe that citizen involvement should be kept to an absolute minimum due to the technical level of expertise needed and the ideal of limited government.

Several authors have expressed concerns over the culture and politics of citizen participation efforts. These authors note that democracy has been malleable over time in the United States and abroad. Conway (1991) and Cobb and Elder (1983) conclude the American democratic ideal was adversely affected by the mass nationalism and Nazism in Europe during the 1930s. These movements challenged the central argument for citizen participation in a democracy; namely that citizens would make rational and reasonable political choices. Citizen participation in government can be compromised by political manipulation, clouded judgment or the general public's inability to adequately assess what benefits the public good (Burleson, 1952). Dye and Ziegler (1981) argue in the *Irony of Democracy* that democracy is government "by the people," but survival of democracy rests with elites. They argue that if the survival of American democracy depended upon the existence of an enlightened citizenry, then democracy would have disappeared long ago. The demise would be caused by citizen apathy and of an ill-informed citizenry related to public policy.

Critics point to the shortcomings of citizens. For example, citizens may have limited interest in participation, ignorance about the government process and may have a poor understanding of specific issues. Policy makers may ignore the citizen's rational evaluation of the costs and benefits of participating given limited information (Dahl, 1970; Kweit and Kweit, 1987). Some critics have stressed broader institutional and political limitations (Rosener, 1978; 1984; Greene, 1982; Abney and Lauth, 1985). Other critics have emphasized the design



inadequacies of participation techniques, such as sociocultural barriers that make public hearings inaccessible to large segments of the community, domination of citizen participation forums by unrepresentative interest groups, and too much reliance on superficial opinion surveys (Milbraith, 1965; Gittel, 1980; Arnstein, 1969; Rosener, 1978; Berry, 1981). Irvin and Stansbury (2004) question whether citizen participation is worth the effort.

### History of Citizen Participation

Citizen involvement in government within the United States has been narrowly defined since its founding. The Federalist Papers stated that a direct democracy was unworkable due to the size and scope of the new country. Representation was seen by James Madison in The Federalist Paper #10 as the only way to minimize the “violence of faction” that produce decisions based upon an overbearing majority. Representation would extend government to a large area and limit citizen involvement via the selection of representatives. The founding fathers believed that ordinary citizens were essentially not qualified to directly participate in governing. This skepticism about the governing ability of ordinary citizens made them limit citizen involvement to that of voting (King & Stivers, 1998). The French political scientist Alexis de Tocqueville in 1831, while examining the fledgling United States democracy, described the tendency for citizen participation and equality in his book *Democracy in America* (1835). In addition, the legal system provided explicit support for citizen involvement in practice by passing the First (freedom of speech and religion), Fifth (protects against government abuse in a legal procedure) and Fourteenth Amendments (citizenship, due process and equal protection clauses) to the Constitution.

The Federal Register Act of 1935 made official agency documents available relating to rule making, proposed rulemaking, meeting notices and other formal actions by federal government agencies. The Federal Register is a daily journal of approved acts by the government and a way for people to be involved in agency rulemaking by providing public comment to proposed rule changes. This Act established judicial review of agency actions and is likely the beginning of modern citizen participation at the federal level. There is evidence that one of the high points for citizen participation and control of government functions occurred in rural areas as a result of agricultural legislation governing soil banks and crop allotment during the administration of President Franklin Roosevelt (Strange, 1972), but this was not widespread.

The Administrative Procedure Act of 1946 expanded and brought uniformity to the requirements for public hearings prior to administrative rule making. Federal regulations require government agencies to publish public notices, conduct a minimum number of public hearings and provide open public access to information. Additionally, many federal rules incorporate citizen participation as an essential part of intergovernmental assistance.

Early attempts at direct citizen involvement did not lead to the kind of participation efforts that were needed and changes started in the late 1940s. The Housing Act of 1949 required participation in urban renewal through the public hearing process. The Housing Act of 1954 and Juvenile Delinquency Demonstration Projects (Juvenile Delinquency and Youth Offenses Control of 1961) involved citizen participation through citywide advisory committees made up of leading community citizens (Hallman, 1972). However, these participation efforts

involved “non-indigenous, blue-ribbon citizens” in an advisory capacity with little or no direct participation by residents of affected areas (Stenberg, 1972). These citizen participation efforts lead to further calls to involve the citizens who were directly affected to be placed on these same committees.

The federal Urban Renewal Act of 1954 mandated direct citizen participation by those affected by urban renewal. Urban renewal consisted of publicly subsidized programs that led to the destruction of older inner city properties and authorized new construction. The act’s initial aim was to clear slums, but subsequent amendments broadened what could be done with the money. Most of these renewal agencies formed a seven to fifteen member advisory board composed of citizen leaders. These leaders had access to other people who could make development successful such as bankers, developers and legislators. Grass root participation was not necessary, but encouraged, when needed to expedite housing and business interests. The hope was that neighborhood citizens would participate if they were allowed in the agency decision making (Burke, 1979).

Another federal response to the slums of the inner city and urban renewal was the passage of the Federal Highway Act of 1956. This act prompted cities to build highways and on ramps as a way to address the slums of the inner city (Jackson, 2008). One byproduct of the Federal Highway Act was the massive displacement of the urban poor without any comparative alternative in housing. Due to the increase in urban unrest, President Johnson initiated a prompt response. President Johnson’s War on Poverty attempted to address complex social needs through increased citizen participation and was a piece of his larger Great Society

legislation. The War on Poverty was a compilation of federal programs targeted to combat poverty in low income, predominantly African American, areas of the United States. This new public involvement was focused on policy implementation and broadening the scope of involvement by the poor. The Economic Opportunity Act of 1964 (War on Poverty/EOA) called for “maximum feasible participation” by the poor in government programs. This act authorized a defined role for citizens in deciding expenditures, design and execution of significant programs.

The core issue with the “maximum feasible participation” phrase was that there was little consensus about either the intended meaning or the precise origins by the administrative task force that drafted it. Even the drafters of the bill recalled no discussion of the term in the deliberations giving rise to the EOA of 1964, inserting it only after a member recognized that it had been invoked several times by another in an all-night drafting session (Yarmolinsky, 1966). The idea of “maximum feasible participation (MFP)” of the poor had been evident in theory based literature, nonprofit advocates, philanthropic circles and U.S. foreign development assistance in the late 1950s (Marris & Rein, 1967). The struggle over defining and implementing the participation clause focused upon jobs and policy making, but the fundamental issue centered on the reallocation of power (Rubin, 1969). This concept could be thought of as the beginning of a substantive change (in citizen participation) from affluent white committee members to the poor minority member. This ambiguous bill was submitted to the House of Representatives (H. R. 10443, 1964) and stated that “Community action would mobilize and utilize, in an attack on poverty, public and private resources...provide services, assistance and

other services...with maximum feasible participation and conducted, administered or coordinated by a public or private nonprofit agency that was representative of the community.”

The authors of the Economic Opportunity Act of 1964 knew that the creation of new anti-poverty policies by themselves would not be sufficient without the creation of locally based community participation. The premise was that there needed to be buy-in and not just from the top down, but from the bottom up (Melish, 2010). Community based participation could (potentially) ensure that the practical barriers to opportunity could be identified and targeted for removal. Local entities could safeguard that leadership, ingenuity and resources were being mobilized to find solutions to local poverty conditions. The framers of the EOA proceeded with the understanding that federal income supports, voting rights provisions and the top down provision of social services were sufficient to guarantee opportunity or sufficient policy solutions. Additionally, new information about the origins of poverty or culture of poverty (Harrington, 1964) and institutional bureaucratic factors related to social service agencies being unresponsive led to the expanded citizen participation language. This understanding led to the legislative language creating “maximum feasible participation” of affected communities in the development, implementation and administration of programs aimed at eliminating the causes of poverty. (EOA, 1964). The Act created an Office of Economic Opportunity that would serve as the national headquarters for poverty interventions with federal oversight, coordination, information sharing and financial assistance.

Maximum Feasible Participation was met with resistance from city governments, who did not want the poor to get decision making power over community action funds. In response, Congress imposed restrictions on community action funds that gave states and local

governments the power to incorporate local Community Action Agencies (CAA) within their own governmental structures. The CAA would identify federally created entities, entitled to federal funding for ninety percent of their program costs for the first two years of operation, after which the percentage of federal funds would decrease. The policy was set up to provide incentives to secure nonfederal funding after the initial two years. However, by early 1965 battles over who had ultimate control over community decision-making authority and use of poverty funds had unleashed a clash between Community Action Programs (CAP) and the formal (state and local) political establishment. Additionally, the EOA of 1964 limited the composition of the Community Action Agency boards to include no more than one third poor people, with the rest equally divided among public officials and private sector representatives. Genuine collaboration did not occur because many of the regulations requiring citizen involvement were interpreted as an instrument for administrative goals. Citizens were seen as clients, whose needs tended to compromise the rational allocation of resources (Jackson, 2008).

The program that generated the most intense controversies was the Community Action Program (CAP). The CAP offered the most promise for reform, but also the most potential for turmoil. Most controversies involved the distribution of power to poor people that often bypassed traditional federal, state, and local bureaucracies. By requiring the “maximum feasible participation of the poor” in Community Action Agencies, the Economic Opportunity Act substantially elevated the role of marginalized people and initiated a new policy experiment. The Economic Opportunity Act (1964) authorized creation of the Office of Economic Opportunity (OEO), the Job Corps, Head Start, the Neighborhood Youth Corps and

the Community Action Program (CAP) program to name a few. The federal antipoverty effort encompassed a wide range of Great Society legislation far broader than the Economic Opportunity Act alone. Other important measures with antipoverty functions including the Civil Rights Act (1964), the Food Stamp Act (1964), the Elementary and Secondary Education Act (1965), the Social Security amendments creating Medicare/Medicaid (1965), the creation of the Department of Housing and Urban Development (1965) and the Model Cities Act of 1966 (Columbia Encyclopedia, 2008).

The Demonstration Cities and Metropolitan Development Act of 1966 (The Model Cities program) saw citizen participation expectations lessened (to widespread citizen participation) and gave more control back to city administrators who attempted to develop a more comprehensive approach to urban problems. The act envisioned “citizen participation filtered through local government” and rejected the direct democracy model of the 1964 Economic Opportunity Act (Jackson, p. 10, 2008). City governments had an obligation to create a mechanism whereby residents could participate in the planning process and provide feedback regarding operations. The emphasis, however, was placed on improved communication between community groups and public officials, not on power sharing between them.

Through community action, the War on Poverty became intertwined with the struggle for racial equality. Urban unrest narrowed the War on Poverty and turned the OEO and the CAP into major anti-riot endeavors. By 1969, over 1,000 Community Action Agencies were in operation, and they offered ready-made organizations capable of dealing with tension on the streets. The Community Action Agencies generally became much less controversial and developed into accepted social welfare institutions carrying out fairly specific services. Despite

repeated calls for its termination, the CAP created agencies that actually became widespread and relatively popular. Mandatory participation was later replaced with “adequate opportunity for citizen participation” in the Housing and Community Development Act of 1974 and the “encouragement of the public” in the Coastal Zone Management Act of 1972 (Day, 1997). The National Environmental Policy Act of 1969 instructed members of the President’s Council on Environmental Quality to consult with the Citizens’ Advisory Committee on Environmental Quality and other groups “as it deems advisable (Day, 1997).” The Federal Advisory Committee Act of 1972 required citizen advisory boards throughout the Federal government and encouraged citizen involvement. In 1999, the U.S. Department of Health and Human Services reported that 96 percent of all counties in the United States were operating Community Action Agencies or their equivalent (Germany, 2010).

#### Citizen Participation Models

Three types of citizen participation models exist in the literature. The three are active, hybrid and passive. Arnstein’s (1969) ladder of citizen participation would fit within these different models. Timney (1992) looked at state energy policy development of three different states and found each state utilized a distinct citizen participation model (along the above continuum) resulting in different outcomes. Thomas (1995) looked at the level of control exerted in managerial decision making. The active model gives the policy process to the public and the administrators serve as consultants or advisors to the people. This model of participation could be viewed as the pure form of citizen involvement and control. The active model is characterized as being proactive, the agency serves as a consultant, citizens articulate



policy and citizens are a part of the decision making process from the beginning. The administrators' primary responsibility will be in the implementation of the final product.

The passive (or traditional) model excludes citizens until the agency has completed its work. Citizens are then asked to approve the draft report or present another point of view. In the end, administrators retain the final say over how the information is used and whether the report will be revised. Citizens have a very small role in this model. The agency controls the agenda, the process is closed, experts make the decisions and citizen input comes at the end of the process in the passive model. The primary difference between the active and passive models is that of administrative control (King & Stivers, p. 93-94).

The hybrid model is a combination of the active and passive models, whereby administrators maintain control over the process, but are much more receptive to public input than the passive model. Public administrators are still viewed as the experts, but public participation and consensus building are the goals. The consensus is then used by the administration to draft the final report. This model is characterized by shared control and decision making. It is an open process where participants have many opportunities to enter into deliberations.

### Modern Responses to Citizen Participation with Government

Different approaches to government came about in response to the complex problems that developed in the last half of the twentieth century. One such approach to government is collaboration. Collaboration is important in citizen participation because it deals with a process, as distinct from a program, agenda or outcome. Collaboration can be defined as a locally based

process where parties come together in a structured way to engage in joint decision making about a problem (Potapchuck & Polk, 1994). The literature suggests that for collaboration to be effective, it must be democratic and inclusive. Collaboration has to be free of hierarchies and must include all stakeholders in the problem being addressed. Effective collaboration involves several common elements: commitment from leadership; sufficient staff; adequate financial support; equal stakeholder participation; continuous evaluation and the willingness to change course (NAMHPAC, 2001). For example in mental health, one study of MHPACs studied three states and highlighted the different types of collaboration that can occur. The study looked at collaboration in the planning process in Arkansas, evaluation in West Virginia and advocacy in Colorado. These three state MHPACs worked with state mental health agencies “to create a dynamic partnerships that build on each other’s strengths and provide a foundation for continued partnership and innovation that can serve as an example for all states (NAMHPAC, 2001).”

Modern public administration involves an inherent struggle between being responsive and collaborating with citizens. Vigoda (2002) in espousing for the next generation of public administration; sees responsiveness as mostly passive and unidirectional reaction to meet citizen needs. Collaboration is seen as a more active and “bidirectional act of participation, involvement and unification of forces between two parties (p. 527).” Bingham, O’Leary and Carlson (2008) argue that there need to be better definitions and conceptualizations of collaboration. Furthermore, they examine the many dimensions of collaboration. Collaboration occurs within and across organizations, within and across public and private sectors, with homogeneous and diverse partners, among those with shared and differing goals,

under voluntary and mandatory conditions, with and without broader public involvement; and on highly contentious as well as less controversial policy matters (p. 6-7). This illustrates just how widespread and heterogeneous the collaboration process can be.

Different terms have developed over the years such as collaborative public management, participatory governance, collaborative governance and deliberation. Collaborative public management is a concept that describes the process of facilitating multi organizational arrangements to solve problems that cannot be solved by single organizations; in other words, “Co-laboring” to achieve common goals based upon the value of reciprocity. Participatory governance is the active involvement of citizens in government decision making by allowing citizens to influence the decision making process. Collaborative governance is used to describe the integration of reasoned discussions by citizens into the decision making of public representatives, especially when approaches are utilized within local governance ([www.ca-ilg.org](http://www.ca-ilg.org)).

Another recent approach to citizen participation in government decision making that has gained more widespread use is deliberation (Mathews and McAfee, 2002). Community deliberation is seen to build on traditional models of public participation by advancing a richer form of citizen involvement in governance processes. The concept of deliberation is built upon what the United States government has called “a basic tenet of Western democratic traditions,” in other words, placing citizens closer to the government affairs will strengthen democracy, stability, and transparency. Deliberation is an approach to decision making in which citizens come together to look for ways to deal with issues and solve community problems (Mathews

and McAfee, 2002). During deliberation, participants consider relevant facts from multiple points of view, discuss and think critically before they can act. That is to say, they are looking for a "stepping stone" to action to better inform public action. In other words, such processes of group reflection are used to render a public judgment as to the best course of action. In short, to deliberate is to weigh the consequences and costs of various options before action (Mathews and McAfee, 2002).

### Different Areas of Citizen Participation Involvement

Many different policy areas within government are required to have citizen participation of varying degrees and this research will look at some of these other areas to provide a baseline comparison with that of citizen participation in mental health. Direct citizen participation is apparent at all levels of government, but tends to be more evident on a local level due to problems of scale. Citizen participation can be found in programs and policy areas such as education, law enforcement, health, social services, criminal justice, environmental systems, community mental health and community development. Citizens can be involved throughout all stages of policymaking from analysis, initiation, and formulation to implementation and evaluation. The environmental, housing and education policy areas that follow will illustrate citizen participation activities in these other areas prior to a discussion of citizen participation in mental health. This is important to provide a baseline comparison to identify similarities and differences between these areas and mental health.

The Environmental Protection Agency (EPA) highlights the importance of citizen participation in the permitting process for both hazardous and municipal solid waste facilities. Public participation initiatives ensure citizen input. Businesses and the state or federal

permitting agency must make information available to the public; citizens can submit comments and request public hearings. A corrective action process has been instituted whereby citizens can have direct involvement in the decision making process of hazardous waste cleanup. The National Environmental Policy Act (NEPA) of 1969 required that environmental impact statements be conducted with citizen input. These impact statements create many litigation opportunities for environmental groups, in particular. There is a growing movement toward collaborative stakeholder participation in environmental policy. Results indicate that the degree of policy change is associated closely with local contextual factors, rather than internal group factors often emphasized in studies of citizen advisory committees and collaborative groups. Perhaps most visible have been changes in U.S. federal agencies, both regulatory (Weber, 1998) and in natural resource management (Wondolleck & Yaffee, 2000).

Several studies show how recommendations from both citizen advisory committees and broad collaborative groups are translated into policy change. A citizen advisory committee (CAC) is a group typically convened by a public agency to represent various interests in developing recommendations about a specific government program or issue (Lynn & Busenberg, 1995). CACs have been used extensively in the United States over the past 40 years, at all levels of government (Lynn & Busenberg, 1995). Whereas some CACs have seen their recommendations adopted, in other instances CAC recommendations have been ignored by the convening agency (Lynn & Kartez, 1995). The number of applications for citizen advisory groups differs with the amount of respect and power the advisory committee is allotted (Callahan, 2002, King & Stivers, 1998). Characteristics of the advisory committee figure

prominently in studies of CAC influence on policymaking. Arnstein (1969) argued that access to resources such as funding and technical assistance was critical for citizen input to be taken seriously in policymaking. Lynn (1987) found that technical expertise and staff support aided advisory council effectiveness in incorporating hazardous waste recommendations into city and county ordinances. Cohen and Sabel (1995) identified CAC composition as a key factor. The Department of Housing and Urban Development (HUD) advocates for citizen participation on the Community Development Block Grant (CDBG). A CDBG requires that participation include certain disadvantaged minority residents of the affected area. An annual Citizen Participation Plan needs to be submitted that documents efforts to enhance participation (HUD 1978) and must provide citizens with reasonable access to local meetings, review proposed activities, outline a grievance procedure and identify how language needs may be addressed for meetings, as needed. (HUD, 2010). Hearings provide a forum for citizens to voice their wishes and concerns, but the government only has to consider the requests. The local administrators of the CDBG have considerable discretion as to the degree of collaboration, how much and what form of citizen participation there will be. As a result, bureaucratic responsiveness is a critical component of citizen participation that may be influenced by both institutional structures and an administrator's personal beliefs to promote stronger relationships with citizens (Bryer, 2007). Government has made efforts to incorporate citizen participation in the budgeting process (Beckett and King, 2002), utilizing citizen surveys (Watson, Juster and Johnson, 1991) and performance measurement for government service provisions (Ho and Coates, 2002).

A closer look at another federal program called Head Start can provide further insight into citizen participation efforts in education. The Head Start program began in 1964 as another part of the Johnson Administration's War on Poverty. This was the first federal program designed to meet the educational needs of children from working class families caught in the cycle of poverty. Head Start program promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families. A key component of Head Start is citizen participation by the parents of children attending the program. The Head Start Performance Standards (2005) compel programs to build partnerships with parents, assist with accessing social and mental health services, provide volunteering opportunities, allow for parental input into program decision making, encourage community advocacy and offer at least 2 home visits per year. Head Start's two generational approach to early childhood education calls for the maximum feasible participation of parents in educating their children (Valentine & Stark, 1997). Several decades of Head Start research has shown that parent involvement in Head Start is associated with children's increased cognitive and social-emotional school readiness (Henrich & Blackman-Jones, 2006). Numerous studies highlight parental involvement and its association with increased activities with children at home (O'Brien et al, 2002), increasingly responsive parenting styles and increased parental well-being (Lamb-Parker, Piotrkowski & Peay, 1987). In sum, parental involvement is associated positively with a child's academic and social skills. Additionally, involvement by parents in Head Start is associated with parental activities at home with the child. Parents can take part in training classes on many subjects, such as child rearing, job training, learning about health and nutrition, and using free

resources in their own community. In fiscal year 2009, twenty six percent of Head Start program staff members were parents of Head Start children and more than 850,000 parents volunteered in their local Head Start program.

Citizen participation in the United States has evolved, particularly from the 1940's, to today. No longer is mere voting enough to satisfy an often uneasy populace craving accountability and transparency. This chapter looked at the multiple factors and actors important to citizen participation in the United States. The multiple actors within the intergovernmental system and outside the system (ex. interest groups) form an elaborate network for policy making. The normative questions of what a government 'should' do, the many types of citizen participation and the modern outcry for increased input to government policy making appear to be a consequence of the "functional realities of the integrated national economy emerging from the forces of industrialization and urbanization, the rise of large corporations, and advances in transportation and communication (Liu, Karlan and Schroeder, 2009, p. 71). Under the guise of "maximum feasible participation" (since the 1960s), citizen participation has expanded into nearly every policy arena. Citizen participation has had mixed results in different policy areas; depending upon the type, level of citizen input, the stage of initial input, technical support and overall decision making authority. However, the federal government utilizes the grant in aid system to continue to influence state policy by requiring citizen participation and advocate for national policy initiatives. The next chapter will highlight the history of mental health care in the United States and take a closer look at citizen participation in mental health policy.



## Chapter 3

### Mental Health System in the United States

The mental health system in the United States can be described as fragmented, at best, and perhaps even broken. The historical context and development of the mental health system is important in understanding the current de facto system and the role of citizen participation. To date, there is no national mental health policy in the United States. Instead, an uncoordinated system developed with the states taking on primary responsibility. However, the federal government attempted to take a more facilitative approach to mental health care policy in the early 1960s. The current mental health system is comprised collectively of the specialty mental health system (mental health professionals), primary care system (general physicians), the human services sector (social services) and the voluntary support network (self-help groups). It can also be broken down into both public and private sectors that are loosely coordinated, but primarily independent from each other. The public sector can be defined as services directly operated by any level of government. Governments can provide services indirectly by providing public funding by way of contracting (privatization) with non-government agencies. The private sector can be defined as services directly provided by private for profit or nonprofit agencies.

As noted in chapter one, a series of concerns are cited in critiquing the current U. S. mental health system. Concerns related to system access, fragmentation, continuity of care, communication amongst public (and private) agencies and lack of consumer input are common criticisms. To better understand the context of the current system, it is imperative to gain an understanding of the history of mental health policy in the United States.

The origins of the mental health services system go back to the colonial settlement period of the United States in the 1700s. The issue of mental illness was seen as a private matter and issues related to caring for the mentally ill were seen as the primary responsibility of family. However, mass citizen migration to cities prompted state governments into action to address the problem in the nineteenth century. The states responded by building institutions known as asylums for those who could not be cared for at home. An asylum is “an institution for the care of the destitute or sick and especially the insane (Merriam-Webster.com, 2011).” The decentralized nature of the American political system, state rights and a lack of a national mental health policy meant that any attempts to transform policy needed to be done by each individual (fifty) state.

### History of Mental Health Reform

Four mental health reform movements have been identified to date. Each reform cycle is associated with alterations in the level of government involvement in mental health delivery (Goldman, Frank & Gaynor, p. 208). This classification of mental health reform movements do not encompass all years from 1800, but does provide a template for looking at substantive changes to the mental health system. Years that are omitted could be viewed as an era of transition from one stage to another or a time period of less significant changes to overall mental health policy. The four mental health care movements included Moral Treatment from 1800 until 1850, Mental Hygiene from 1890-1920, Community Mental Health from 1955-1970 and Community Support from 1975- present (Surgeon General, 1999). While the four periods are pretty well established, I believe that a fifth time period is now appropriate. The fifth

mental health reform movement related to today could be called Mental Health Transformation from 1999-present. A report and commission was established, in part, because of the Surgeon General's report on mental health in 1999. It is this period that will be utilized for this research. These reform movements shifted various responsibilities between local, state and federal governments based upon the rationale for treatment.

### Moral Treatment Reform

"Moral treatment" did not begin until the very end of the 18th century, after the Revolutionary War. Prior to this time, care for the mentally ill was done mostly by family. This shift came about as a result of reformers such as Dorothy Dix, who documented the inadequacy of existing treatment for the mentally ill and worked to influence public officials to make policy changes. Dix documented the horrid and often abusive treatment of the mentally ill in jails, poorhouses and prisons in Massachusetts. This documentation led to a presentation called the Memorial to the Massachusetts Legislature to MA lawmakers in 1843 (Dix, 2006). The manuscript was a 32 page compilation of the conditions related to treatment of insane persons. Furthermore, Dix began to examine each state and lobby their respective state officials for more humane state funded treatment of the mentally ill. Mental illness was becoming redefined from an economic and social problem to that of a medical condition. Traditional attitudes towards madness were in a state of flux because up until this time the indigent insane were lumped together with deviants on the lower rung of the social ladder. The assumption during this time period was that insanity was treatable and improved living conditions could help the mentally ill. The resulting type of treatment occurred inside state built asylums that

specialized in caring for the mentally ill. This (moral) treatment referred to the return of the individual to reason by the application of psychologically oriented therapy (Grob, 1994).

Dix's advocacy was quite successful as evidenced by the growth of mental health asylums. There were only 13 state mental institutions in the United States when she began her crusade and toward the end of her campaign there were 123 (West's Encyclopedia of Law, 2005). Dix even lobbied for a bill that passed both houses of Congress in 1854 called the Land-Grant Bill for Indigent Insane Persons. This bill would have granted public lands to several states to build asylums for the indigent insane (deaf, dumb and blind), but was vetoed by then President Franklin Pierce. President Pierce believed that the federal government should not be in the business of social welfare because mental health was the domain of the states. During this period of moral treatment, states built the asylums and required both state and local governments to finance the operations. As a result, the asylums' quality of care suffered due to being chronically underfunded and overcrowded. Local governments, in response, would send the mentally ill to jails and almshouses (housing for poor) to avoid financial responsibility. These substandard conditions (in the asylums) led to the passage of state laws to centralize state responsibility for mental health services in every state and led to the next movement called mental hygiene reform.

### Mental Hygiene Reform

The Mental Hygiene reform movement ran from the 1890s – 1920s. This period rested on the belief that early treatment was expected to prevent chronic mental illness. Reformers of this period called for an expansion of scientific medicine in asylums. This reform movement

was bolstered by the passage of State Care Acts. These Acts centralized mental health care financing responsibilities to that of the state. This state centralization of responsibility leveled the care discrepancies created by variation in local government's commitment to the mentally ill poor (Goldman, Frank and Gaynor, p. 209). New York passed the first State Care Act in 1890 asserting that the mentally ill were wards of the state. Every state passed a State Care Act between 1890 and World War I. This action prompted local governments to begin sending their chronic mentally ill and demented patients to asylums in an effort to reduce local government costs. In fact, state care for the mentally ill became the general rule in the twentieth century (Grob, 1983). During this time, several psychiatric units were opened in general hospitals in an effort to move mental health care into the mainstream of health care. Asylums were renamed mental hospitals during this time period, with a former mental health patient named Clifford Beers leading reform efforts. He formed the earliest committee in the United States called the National Committee on Mental Hygiene (NCMH) in 1909 and later described the deplorable conditions in mental hospitals in the autobiography *A Mind That Found Itself* (1913). The goal of the NCMH was to improve the life and treatment of the mentally ill. Beers did not attempt to organize people, but wanted to network with people in their communities. This committee still exists today and is known as the nonprofit organization, Mental Health America. This organization continues to advocate for those with mental illness on a national and state level to the present day.

The 1930s to the early 1950s can be seen as a time of transition from the Mental Hygiene Reform movement to Community Mental Health Reform. However, the changing dynamics within mental hospitals during this time period were striking. State hospitals had an

increased percentage of long term chronic patients. In fact, nearly 80 percent of beds were occupied by the chronically mentally ill by the 1930s. States had decided with the State Care Acts that shared responsibility with local government did not lead to the kind of quality of care that many envisioned. These changes combined with the influx of many senile (and aged) individuals into state hospitals led to a change in policy direction. To illustrate this change, the proportion of inpatient admissions by individuals from primary organic disorders (i.e. dementia) related to primary physical causes increased to 42 percent between 1922 and 1940. Financial neglect of mental hospitals due to the Great Depression (1930s) and World War II (1940s) exacerbated severe problems within these hospitals. However, the state of mental hospitals was as much a function of the patient population as it was any type of callous policies (Grob, 1992).

The Mental Hygiene movement and the other factors mentioned above led to the passage of the National Mental Health Act of 1946 under U. S. Public Law 79-487. This Act authorized the Surgeon General to improve the mental health of citizens through research on the causes, diagnosis and treatment of mental illness. The argument made was that community oriented policy would be more efficient than the inpatient mental hospital care. Further strengthening this argument, Albert Deutsch (1948) in his landmark book, "The Shame of the States" reported public revelations that most state hospitals were overcrowded and patients were living in squalor. The National Institute of Mental Health (NIMH) was established in 1949 and was the first federal agency to focus upon this mental health directive, signaling a major shift from the state to federal level as the center of innovation in U S mental health policy (Brand, 1965).

## Community Mental Health Reform

The mid 1950s ushered another mental health movement due to increasing calls for community based solutions as an alternative to substandard inpatient care. The Community Mental Health movement (1955 – 1970) was highlighted by the passage of U. S. Public Law 84-182 that created the Joint Commission on Mental Illness and Health in 1955. The Commission spent over five years scrutinizing mental health services around the U. S. and published a report called Action for Mental Health (1961). This report made multiple recommendations for the treatment of mental illness. Recommendations included calls to stop building large mental institutions, argued that only twenty percent of the 227 mental hospitals were actually therapeutic, while highlighting a troubling rejection of the mentally ill by citizens (and professionals). This report formed the basis for the future community mental health movement. Citizen or consumer participation was limited during these earlier reform movements and it was not until the Community Mental Health reform movement in the 1950s that consumer input was encouraged.

Community Mental Health Reform came about as a byproduct of the abuses documented within asylums. This reform movement supported treatment outside of state hospitals and in the community. The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (CHMC) (Public Law 88-164) provided the first direct federal involvement into mental health in over 109 years, mandated deinstitutionalization of thousands of psychiatric patients from state asylums and required substantive consumer input

by creating citizen mental health boards. This Act serves as a starting point for the demand of citizen participation.

Deinstitutionalization can be defined as the release of psychiatric patients from institutional care to treatment in the community. The goal was to decrease the inpatient psychiatric population of the states by fifty percent over twenty years. For example, the census of the nation's state hospitals (county and state) reached its peak of 560,000 in 1955 and there has been a dramatic decline to 52, 539 in 2005. On average, only 6.5 percent of the 1955 inpatient beds were still available in 2005 ([treatmentadvocacycenter.org](http://treatmentadvocacycenter.org)). The goal was to create a full and coordinated range of services that included the dual policies of outpatient, inpatient, consultation/education, partial hospitalization, and emergency/crisis intervention (Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). Prevention of mental illness and promotion of mental health was a priority for the first time by the federal government. The most striking aspect of the new law was the absence of any mention of state mental hospitals.

Categorical grant funding enabled community mental health centers (CHMCs) to serve all members of the community, regardless of their ability to pay, effectively creating a mental health safety net. This act consisted primarily of construction grants for communities to build outpatient centers and provided the first couple of years operating funds to grantees. The original intent was to build 2,000 CMHCs, but only a quarter had been built by 1975. By 1980, only 740 were operating and covered only about 115 million people in their catchment areas or access for about 50 percent of the country. The CMHC of 1963 envisioned catchment areas as being geographic regions with a population of between 75,000 and 200,000 (Langsley, 1980).



The concept of initiating high federal funding support and gradually reducing it was based on the assumption that the state and local communities would take over their support. Few CHMCs worked to generate additional local financial support or plan for the future (U S GAO, 1974). The framers of the CMHC legislation assumed that state and local resources would follow the mentally ill patient after being discharged from state hospitals, but this did not occur. Additionally, the assumption that significantly reduced spending on state hospital care would allow state governments to redirect the savings to CMHCs never occurred. Cost savings usually did not happen as envisioned and state funding was generally inadequate to provide care for the many federal mandates. Congress further compounded the problem when it passed legislation in 1968 that expanded the role of CMHCs to serve more populations including substance abusers, children, and the elderly. This broadened mission and fewer resources caused CMHCs to focus upon a broader population other than the severely mentally ill (US GAO, 1977, Grob, 2001). This new federal role had major implications for future intergovernmental relations because health care services were historically under the control of local and state governments. However, the states were reluctant to support mental health funding, except for basic custodial care. Federal involvement was limited to indirect provisions, prior to this time, except within the Veteran's Administration Medical Centers (VAMC) for veterans. The VAMC is essentially universal health care provided by the federal government to eligible veterans.

The federal government began forging more direct relationships with local communities, effectively bypassing the existing state hospital infrastructure during this time period. This action diminished state authority and policy influence, while increasing federal and professional

importance under the new law. Congress provided money for state wide planning, but state officials' authority over policy decreased. The absence of any linkage between the new community mental health centers and the existing state mental health system was ominous. These two structures functioned in virtual isolation from each other and subsequently served different types of clientele. The new system essentially ignored the needs of the severely mentally ill that resulted in pushing care of this population back to a secondary position (as the general medical system tends to do). The system encouraged local systems to be innovative, but a lack of oversight mechanisms allowed them to serve a population other than the serious mentally ill. However, the CMHCs operating budgets did not rise to expected levels due to the competing demands of the Vietnam War.

### Consumer Mental Health Movement

Citizen participation in mental health has mirrored calls for increased citizen involvement in other policy areas, but it was not until the passage of the Community Mental Health Centers Act of 1963 (that it became a requirement). Mental health pioneers have been championing more humane treatment of the mentally ill as far back as the 1840s (Dorothy Dix), but citizen involvement or consumer reforms did not come about until after the 1963 Act passage. Demand developed for increased citizen participation in mental health policy due to implementation issues of the CMHC. This demand resulted in the formation of a corresponding grass roots consumer movement in the decades that followed.

Prior to this time, treatment of the mentally ill was usually dictated by mental health professionals with little input by the client. This parallel, although less prominent, consumer

movement called for increased citizen participation (like other policy areas at that time) beginning in the 1960s. However, the consumer movement did not begin to hold until the 1970s. Oppression, overmedication, incarceration and coercion had occurred for many years in mental health facilities or asylums causing calls for reform. Consumers began meeting in several cities around the country (mostly on the coasts), talked about their experiences and developed an agenda for change.

The movement gained prominence over civil commitment procedures that placed the mentally ill into mental health inpatient units against their will. Civil commitment can be defined as “a process in which a judge decides whether a person with symptoms of severe mental illness should be required to go to a psychiatric hospital or accept other mental health treatment for treatment beyond the emergency hold period. “Civil commitment exists in all states, but the standards that must be met for it to occur vary from state to state” ([treatmentadvocacycenter.org](http://treatmentadvocacycenter.org)). Furthermore, a lack of community investment led to service gaps in many areas such as housing, social services and medical coverage. These all played a role in the development of the consumer-survivor movement.

The consumer movement initially developed mutual support groups and consumer run services in the community. Unrest among former mental patients led to the formation of several consumer support groups that developed differing philosophies and missions. These support groups began what can be described as the antipsychiatry consumer movement. Three distinct groups developed of ex patients. First, those that wanted to end psychiatry and the mental health system due to poor treatment and coercion. Second, ex patients who wanted to

reform the mental health system with the aid of concerned policy makers and professionals. Third, a group of ex patients who believed the current system was adequate. However, this group was made of up long term patients who were dependent on the mental health system and believed that they would never recover. These patients were characterized as being institutionalized. Institutionalization leads to changes in basic changes self-concept that these former patients are sick, act sick, are unable to function outside of the hospital setting and apathetic about leaving (Townshend, 1976).

This movement was patterned after the civil rights movement, while emphasizing self-help and advocacy; personal empowerment, recovery and social change (Everett, 1994, Campbell, 2005). At the same time, the early survivors' movement was not aimed at influencing the mental health system; but developing an alternative system of support. These groups were mostly small and located on the two coasts. There was neither any major outreach effort nor financial support from state mental health systems during this time. Activities included demonstrations, development of values and position statements and an Annual Conference on Human Rights and Against Psychiatric Oppression. Organizations based upon advocacy and criticism of the psychiatric system grew out of the social movement for the liberation of psychiatric survivors (Chamberlain, 1978, 1984, 1990). This social movement wanted a place at the policy table and wanted to reform the often abusive mental health practices of the past. The most common description of the mentally ill individual was the 'psychiatric inmate.' This increase in the mentally ill inmate coincided with the ongoing policy of deinstitutionalization. In fact, the number of mentally ill in correctional settings increased sharply at around the same time as the Community Mental Health Act of 1963. The expansion of entitlement and disability

programs strengthened deinstitutionalization by providing resources that made it possible for the mentally ill to live in the community. However, a lack of funding and coordination between mental health and social services left many consumer-survivors without a safety net. As a result, self-help support groups comprised of former patients emerged as a critical factor in consumer survival during this time.

### Community Support Movement

The Community Support Movement was initially delineated from 1975 to the present day. However, this movement should be reclassified from the time period from 1975- 1998. Developments from 1999 to the present have been important enough (for this research) to break the time periods into new fifth period (1999 – present). The CMHC Act Amendments of 1975 (P.L. 94-63) mandated more detailed requirements by community mental health centers by emphasizing comprehensiveness and accessibility to all persons regardless of ability to pay. These Amendments required an expansion of core services by mental health centers from 5 in 1963 to 12. This expansion included services for children, the elderly and for those with substance abuse problems.

The federal government became involved when the National Institute of Mental Health (NIMH) initiated the Community Support Program (CSP), in 1977, to begin addressing the multiple problems resulting from deinstitutionalization. The CSP encouraged states to develop a comprehensive system of community support systems for mentally ill adults. The consumer movement became even more diverse in 1979 with the creation of the advocacy organization named the National Alliance on the Mental Illness. This organization involved families of the

mentally ill and advocated to secure funding for research on the biological origins of mental illness.

Difficulties with implementation of CMHC came about because a new infrastructure had to be created and numerous problems with the CMHC boards. One such issue involved citizen participation on the CMHC boards. Research prior to P.L. 94-63 consistently documented significant problems in citizen participation efforts by CMHCs. Robins and Blackburn (1974) found that governing boards were dominated by social elites. New, Holton, and Hessler (1971) in a study of citizen participation in inter-agency relations, found that middle-class patterns of citizen participation, like elitist governing boards, can pose significant problems in poor communities. They recommended greater involvement of consumer representatives in planning, control, and administration. Chu and Trotter (1974) and the Comptroller General (1974) criticized the low level of citizen participation in the management of CMHCs. Paschall (1974) reviewed the literature on citizen participation in CMHCs and documented many deficiencies in implementation. The failure of the CMHCs to address the primary needs of their primary target population (severe mentally ill) had been well highlighted (Chu and Trotter, 1974).

Other obstacles to participation included the interests of mental health professionals who dominated the boards (Checkoway, 1979, Caro, 1981) and professionals, who preferred provider controlled mental health governance (Pinto & Fiester, 1979). In addition, professionals did not fully respect citizens who were not adequately prepared or trained like themselves; this led to a general feeling of illegitimate participation by citizen group members

(Checkoway, 1979). Members on the boards did not have the support of their constituencies and had differing views over the types of technical assistance needed for citizen participation. Funding levels were inadequate to maintain and operate the boards (Caro, 1981). The roles of citizens were constructed so that the boards either had no substantial power over funding decisions or were not independent of the parent organization.

As a result of implementation issues in the 1970s, training programs for citizen members of boards began to appear. Manuals outlining procedures for citizen participation in goal setting and evaluating a CMHCs progress were made available. For example, the National Institute of Mental Health created and released a number of orientation manuals regarding citizen participation (NIMH, 1979, 1981). The assumption was that direct participation of citizens in the development, implementation and evaluation of CMHC services could serve to strengthen the quantity and quality of mental health services (DHEW, iii, 1979). The range of participation included serving on advisory boards or governing boards to volunteering to perform a variety of service functions at centers. The advisory boards were required to assure community residents input into such areas as goals, planning, policies, operation of services and evaluation. Each CMHC had to have a Board of Directors, an Advisory Committee or both. The Advisory Committee had to be comprised of at least 50 percent citizens from the CMHC catchment area. The orientation manual for Citizen Boards of Federally Funded Community Mental Health Centers defined the role advisory committees would play; they do “not make policy, they advise on policy; they do not make financial decisions, they advise on financial matters (HEW, 1979, p. 8).”

Successful citizen inclusion into the mental health system was not without tradeoffs and continuing issues. Continuing consumer issues are related to the potential loss of consumer values, involuntary treatment and restraints. Too many people end up in jails or homeless and funding issues continued to impact access to care. Finally, mentally ill consumers die twenty five years earlier than the non-mentally ill.

### The Reagan Block Grants

The 1980s were a transitional time for the consumer movement and federal mental health policy. The idea of involving consumers in policy making had been gaining credibility during the previous decades and the federal government began encouraging consumer empowerment beginning in 1984. Empowerment can be defined as having the right to make one's own health care choices and is now frequently invoked as one of the fundamental measures of an enlightened health care system (Tomes, 2006).

The Mental Health System Act of 1980 (Public Law 96-398) was the result of a Presidential Commission (Carter) that had studied the mental health system in the United States and had made over 100 recommendations for improvements to the fragmented system. However, newly elected President Reagan pushed for a repeal of the provisions of this Act. The Omnibus Budget Reconciliation Act of 1981 achieved this goal. This law returned most of the direct responsibility for mental health care back to the states in the form of block grants and reduced the mental health budget by 20 to 25 percent. This Act created the Community Mental Health Services Block Grant in 1981. The Community Mental Health Services Block Grant is the only major federal discretionary program designed to support community-based



services for people with mental illnesses. This block grant gives states flexibility to: (1) fund services that are tailored to meet the unique needs and priorities of consumers of the state public mental health system; (2) hold providers accountable for access and the quality of services; (3) coordinate services and (4) blend funding streams to help finance the broad range of supports that the mentally ill need to live safely in the community. This 'New Federalism' signaled a dramatic shift to less federal involvement in many policy areas which was in sharp contrast to the policies of the 1960s and 1970s.

The next important piece of federal mental health legislation occurred in 1986 with the State Comprehensive Mental Health Plan Act (CMHPA) and compelled states to devise detailed service plans emphasizing the needs of the seriously mentally ill to remain in compliance to receive federal mental health block grant funds. Comprehensive mental health planning was required to receive these funds (Library of Congress, Thomas, 1986). The Act (Public Law 99-660) required the inclusion of at least 50 percent inclusion of various private consumer groups in relation to state employees on the Mental Health Block Grant's mental health planning council (MHPAC) of each state. This was viewed as a significant step forward toward consumer equality. The focus became mainstreaming, collaboration and becoming gainfully employed by mental health systems. This focus led to the first state funded self-help groups, peer support programs and early drop in centers. This marked the beginning of statewide consumer run organizations, led to a decline in radical groups, passage of consumer rights protection legislation and saw more consumers sitting on decision making bodies. These activities substantively expanded citizen participation and feedback by consumers at the state level. The CMHPA was a direct federal attempt at addressing citizen participation issues in mental health

at the state level. As a result, it can be argued that it was not until the creation of the Mental Health Planning and Advisory Councils (MHPAC) in 1986 that any form of uniformity developed within all states (and U S territories) in mental health. Mental health planning and advisory councils (MHPAC) now exist in every state and U.S. territory as a result of a series of federal laws since 1986. Planning councils represent direct consumer input while assuring attention to the community system of care for the mentally ill.

The responsibilities of the MHPAC were supposed to go beyond participation in the development and review of the state's annual federal block grant plan. Federal law envisioned planning council involvement in the public mental health system as advocates for persons affected by mental illness, as participants in the review, evaluation and monitoring of the public mental health system. The State Mental Health Services Plan Act of 1986 intended that the "State Plan will be a vehicle by which there will be the establishment/or further development and implementation of organized community-based system of care...recognizes that a comprehensive system of care goes well beyond the mental health services for treatment and prevention to include case management, psychosocial rehabilitation, vocational rehabilitation, housing, income support, health and dental care, food, and other social services (1986, p. 8)." Furthermore, the bill encouraged states to develop measurable goals, promotes case management in every State plan and provides outreach to the chronically mentally ill homeless population. The legislation mandates that certain other state agencies be involved with the mental health planning councils that include Medicaid, mental health, education, criminal justice and social services.

The 1990s saw a reorganization of mental health and substance abuse services at the federal level. The federal Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992 (ADAMHA) created the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA and the Center for Mental Health Services (CMHS) are charged with administering the Community Mental Health Services Block Grant (CMHSBG). One important aspect of administration is calculating the funding formula for each state (and territory). The current formula for distribution of the mental health and substance abuse block grants was part of this legislation. The formula allocates ninety five percent of funds prescribed by the Act. Criteria used to calculate state allotments of the Community Mental Health Services Block Grant included total personal income; state population data by age groups (total population data for Territories); total taxable resources; and a cost of services index factor that needs to be updated every three years (SAMHSA, 2012). Additionally, the law allows a five percent set aside for technical assistance, data collection and evaluative services.

At the same time, the 1990s saw the consumer movement put forward the theory that recovery was possible. The consumer movement showed that people do not have to accept a life of low expectations, dependency and minimal achievements. Additionally, the consumer movement became an important part of mental health history because it focused on that of the consumer, survivor, client or ex patient who fought for empowerment to gain a voice in their treatment. The term 'consumer' referred to people who received mental health services and had a right to be involved in their treatment. This consumer movement sought to have a greater role in policy, program planning, advocacy and service delivery. Others viewed

themselves as ‘survivors’ of mental health care or as ex patients. U. S. activists sought to unite these terms under one umbrella or movement (Wallcraft, Schrank & Amering, 2009).

The consumer movement is responsible for the creation of peer support and self-help groups that have led to consumer operated services throughout the United States. Consumer-survivor run groups, employment and educational opportunities began to flourish. The states viewed supported employment as a cost effective way to become involved because of the lower salaries commanded by non-professionals. The recovery movement stood for self-determination and choice, rights protection, stigma/discrimination reduction, peer support programs and the concept of recovery. The byproduct of this movement was growth in employment within the mental health system. Expanded peer support programs with state mental health system funding, federal funding of consumer/survivor technical assistance centers was initiated and has this time period has been referred to as the “decade of recovery” (Anthony, 1993). Consumers began to demand greater input in research initiatives and evaluating treatment outcomes. The health care system’s focus on quality assurance programs and evidence based practices led to the expansion of consumer involvement due to studies showing that inclusion of measures important to patients increased the likelihood of therapeutic success (Campbell, 1997).

### Recent Federal Mental Health Efforts

Recent federal efforts to highlight issues with the mental health policy included the U S Surgeon General’s (1999), two legal advocacy decisions, and the New Freedom Commission on Mental Health (2003) reports on the mental health system. The landmark report of the mental

health system completed by the U. S. Surgeon General (1999) framed mental health as a public health problem that must be addressed. This report described the fragmented mental health system, described what mental illness is and advocated for increased access to quality services.

Two legal advocacy endeavors had a direct influence on mental health policy. One was a congressional act in 1986 and the latter a Supreme Court ruling on the Olmstead Act in 1999. First, The Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), P.L. 99-319, was passed in 1986, after congressional hearings on abuse and neglect in state mental hospitals (Care of the Institutionalized, 1985). The PAIMI Act funds protection and legal advocacy programs in the fifty states. This Act allows for independent investigations of complaints related to abuse and neglect of individuals with mental illness. Each state established their own priorities with the help of its mental health advisory board, governing body and clients (Overcamp-Martini, 2009). Second, was the U. S. Supreme Court (1999) decision finding that unjustified institutionalization of individuals with mental illnesses constituted discrimination under the Americans with Disabilities Act (ADA). The decision in *Olmstead v. L.C. and E.W.*; caused the U.S. Department of Health and Human Services to develop policies to ensure compliance by the states. The Olmstead Act upheld the civil rights of people with disabilities to live, work and socialize in the community that they want (Christensen & Byrne, 2013). This decision supported two important ADA regulations. The first is to provide services in the most integrated setting that was appropriate to the needs of those with a disability. The second requires that all levels of government make reasonable modifications in policies and practices so as to avoid discriminating on the basis of disability (Desonia, 2003). The Supreme Court decision required each state to create an Olmstead Plan with the intent of increasing

community integration. The definition was left open to interpretation that caused some states to develop strategic planning approaches to meet this goal. As a result, states focused on diversity of legislative action, market based approaches and program linkages (Ng, Wong & Harrington, 2009). Research with disabled individuals have identified personal assistance services, access to public accommodations, receiving aid for employment and appropriate housing have been proven to promote independence (Cox, Stewart & Rosenbaum, 2003). However, problems with implementation existed related to litigation. This litigation resulted in few states implementing a plan designed fully to address Olmstead's aims and goals at the court-mandated "reasonable pace" a decade later (Bazelon Center, 2009).

The U. S. Supreme Court decision coupled with the U. S. Surgeon General's report in 1999 led the formation of The New Freedom Commission on Mental Health of 2002 (by then President George W Bush) that looked to fundamentally transform the mental health delivery system in the United States. The system was to become one that is consumer and family driven that focused upon recovery. The Mental Health Commission was charged with conducting a comprehensive study of the problems and gaps in the mental health service system. The Commission's intent was to study the mental health service delivery system and make recommendations to improve the system, so that individuals with mental health issues can fully participate. Additionally, make concrete recommendations for immediate improvements that the federal, state, local and private health care providers could implement. There were five principles that were to be addressed and included: proposals to improve the mental health outcomes; promote collaboration among providers; maximize existing resources, reduce regulatory barriers; use mental health research to influence service delivery; and promote

innovation, flexibility, and accountability at all levels of government (SAMHSA.gov, 2002). One of the most striking findings of the Commission was the time lapse between research and practice. An earlier report by The Institute of Medicine (2001) called *Crossing the Quality Chasm: A New Health System for the 21st Century*, showed the lag between discovering effective treatments and utilizing them in routine patient care is about 15 to 20 years.

The Mental Health Commission wrote in its Executive Summary to then President Bush in 2003 that “the time has long passed for yet another piecemeal approach to mental health reform. Instead, the Commission recommended a fundamental transformation of the Nation’s approach to mental health care. This transformation must ensure that mental health services and supports actively facilitate recovery, and build resilience to face life’s challenges. Too often, today’s system simply manages symptoms and accepts long-term disability” (2003). The Commission identified fragmentation and gaps for the mental health system, a lack of a national priority in mental health and high unemployment to highlight a few of the conclusions. This bold new vision for mental health saw a productive mental health system as consumer or citizen driven. The states were to develop a comprehensive mental health plan to outline responsibility for coordinating and integrating programs. The state plan would include consumers, their families and create a new partnership with the intergovernmental system. The plans addressed the full range of treatment and support service programs that mental health consumers and families need (New Freedom Commission, 2003).

In sum, the Presidential Commission (2003) and the Surgeon General’s (1999) reports underscored the challenges facing the current mental health care system in the United States.

The following section highlights the complexity of the mental health system and the obstacles that remain:

- First, the United States does not have a national mental health care policy, so each state has its own. That means there are 58 different state mental health plans, budgets and priorities. While this design is positive for states because they can adapt their programs to the unique conditions in their state; it has the disadvantage of creating disparities in services amongst the states. Mental health is singled out more than any other public health or medical discipline by the federal government for exclusion and discrimination because it is considered the principal domain of the states (Urff, 2004).
- Second, the nature of the problem and changing definitions of mental illness have a direct effect upon public policy development. The basis of the definition has moved from colonial times to the present day. Early explanations have gone from being culturally deviant and being possessed by the devil to modern day explanations of having an illness. Now, the U S Department of Health and Human Services in Healthy People 2020 (2010) defines mental disorders as “health conditions that are characterized by alterations in thinking, mood, or behavior...which are associated with distress and/or impaired functioning and spawn a host of human problems that may include disability, pain or death. Mental illness is the term that refers collectively to all diagnosable mental disorders.” Policy design arises from problem definition, but a general lack of consensus of the nature of the problem of mental illness does not lead to a collective sense of purpose for mental health policy.



- Third, the growing consumer movement is sometimes conflicted on how mental illness should be defined. For example, the National Alliance for the Mentally Ill wants to establish mental illness as a brain disorder because it believes that the definition change will lead to increased funding opportunities (Jacobson, 2004). Other interest groups identify other environmental factors such as poverty as causing mental illness.
- Fourth, fragmentation of services and the management of sometimes difficult relations between all levels of government, public and private spheres add to the problem (Brown and Stockdill, 1972: 678-680). Additionally, there is no clear dividing line between public and private spending on mental health. Public officials have a say over the activities that private providers can do through regulation and public health insurance pays for much of the care for the mentally ill, but no one seems willing (or able) to clearly illustrate the division. This point continues to be highlighted by the Community Mental Health Services Block Grant requirement that there be a breakdown of private vs. public expenditures in state comprehensive plans (but states have not complied with this provision).
- Fifth, the role of stigma as a problem associated with the mentally ill cannot be understated. Stigma can be defined as a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against individuals with mental illnesses (New Freedom Commission on Mental Health, 2003). Stigma creates barriers to providing and receiving effective treatment and can lead to inappropriate treatment, homelessness and unemployment. The stigma associated with

mental illnesses is fundamental to discrimination in housing, employment, and insurance. Stigma prevents treatment and impedes recovery.

- Sixth, a new behavioral health care strategy was implemented in the 1980s that fundamentally changed how both inpatient and outpatient costs could be contained (Goldman et al, 2006). This strategy became known as the managed behavioral health organization (MHBO). This specialized type of managed care became increasingly popular into the 1990s to keep costs down, improve patient outcomes and increase system efficiency to encourage providers to offer medically necessary services. Throughout the 1990s, states delegated mental health services contracts to private and nonprofit organizations.
- Seventh, mental health parity continues to be a major concern for advocates. Parity concerns equal coverage for mental health care as primary medical care. Typically, health plans have required higher co-payments, greater deductibles, placed limits on the number of outpatient visits and inpatient days for mental health conditions. Parity laws were intended to diminish this disparity when failures by private insurers create significant cost shifts to the public mental health sector. However, insurance providers created a parallel, more restrictive set of rules for mental health because of the (almost doubled) annual cost increases for mental health in the preceding decades. The passage of the Mental Health Parity Act of 1996 (PL 104-204) helped to increase access to care by forcing insurance companies to expand and extend mental health coverage limits. The Act attempted to bring insurance coverage for mental health treatment to an

equivalent level as general medical treatment services. Since the mid-1990s almost every state had passed mental health parity laws. However, the exemptions in state laws caused only 20 percent to be covered for some mental disorders and 3 percent to receive coverage for all mental disorders (Buchmueller et al, 2007). The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was far more broad than the 1996 parity law. This act requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations for mental health or substance use disorder benefits are on par with general medical benefits.

- Eighth, chronic homelessness is another prevailing issue. The deinstitutionalization of the mentally ill affected approximately 2 million seriously mentally ill and led to at least twice as many living on the streets or shelters than in public institutions. Approximately one third of homeless individuals are seriously mentally ill (Torrey, 1988). Adding to the problem of homelessness was the increased incarceration of the mentally ill. The number of mentally ill in correctional settings increased sharply at around the same time as the Community Mental Health Act of 1963. Thomas Fagan (2003) argued that three factors contributed to the rapid increase to the mentally ill in criminal justice settings. First, tougher sentencing laws whereby more people are in jail for longer periods of time. Second, deinstitutionalization by state mental hospitals has resulted in more homelessness and criminal justice involvement. Many of the functions of state psychiatric hospitals have been assumed by the criminal justice system. Third, increased drug enforcement has increased the number of people incarcerated for drug offenses.

- Ninth, Medicaid led to a rapid decline in elderly patients in state mental hospitals because states had a financial incentive to decrease costs by transferring this population to nursing homes after passage of the Grants to the States for Medical Assistance Programs Act in 1965. Medicaid is a jointly financed federal and state partnership for indigent medical assistance programs. Medicaid's shift in funding tended to increase the fragmentation of services by decentralizing mental health services between the federal government and the states. States were not eligible for Medicaid reimbursement for patients that were in state psychiatric hospitals (in most cases). However, states were able to collect for nursing home placements. States began to send patients to long term facilities such as nursing homes or community based group homes, thus limiting the state financial burden for this population. Medicaid's complexity surrounding who is eligible, what services are paid for and what services are delivered adds to the confusion. The Federal Medicaid statute defines over 50 distinct population groups as being potentially eligible for States' programs. However, the federal government failed to adapt Medicaid rules and regulations to assist the severely mentally ill.

In response to these problems, the Substance Abuse and Mental Health Services Administration issued a report named the Federal Action Agenda: First Steps (2005). This report was based upon the 2003 New Freedom Commission's recommendations to transform the mental health system. This report called upon the Federal Department of Health and Human Services to collaborate with six other federal departments included Housing and Urban Development, Justice, Social Security Administration, Labor, Veterans Affairs and Education on

mental health policy issues. This federal government culture shift was further evidenced by SAMHSA's National Consensus Statement on Mental Health Recovery (2006). The SAMHSA report emphasized basic consumer principles; a concept of recovery attributed to consumers and has initiated new types of services such as peer support and consumer assistance programs. Moreover, committees at all levels of government have to have consumer representation.

Another federal effort to understand the effectiveness of the Community Mental Health Services Block Grant was published in 2010. The study was called an *Independent Evaluation of the Community Mental Health Services Block Grant* (2010). The evaluation sought to answer three main questions surrounding the block grant: First, was the Block Grant being implemented in terms of congressional intent? Second, was the Block Grant achieving the results it was created to achieve? Third, did the Block Grant promote innovation? The study utilized personal interviews, web based surveys, qualitative data extracted from the state plans and implementation reports and outcome measures from the Uniform Reporting System (2004 – 2006) for 19 states. The study surveyed people directly involved with the block grant program including the federal reviewers, State Mental Health Authority representatives and planning council members with the Logic Model as a template.

The results indicated that the block grant was being implemented according to congressional intent, the planning councils played a significant role, the block grant is leveraging block grant funds to expand its effect on mental health systems and the states acknowledge the positive role the block grant has on innovation (SAMHSA, 2010). This study is

particularly relevant to this research because a piece of the evaluation covered the mental health planning councils and concluded that the councils do have “varying degrees” of influence on state mental health systems. However, seven (36.8 percent) of 19 States reported that their Planning Councils do not make substantive recommendations to the State Plan. States reported that they consider all recommendations made by Planning Councils.

Recommendations that are appropriate and feasible are incorporated into the State Plan. Yet, only about half of States were able to give an example of a Planning Council recommendation they incorporated (p. 25). These results seem to contradict the significant role of planning councils as proposed. However, the study only looked at 19 states, in one year and sought limited information from stakeholders. It did not seek to understand differences in planning council influence. Moreover, the limited timeframe (single year) of the data and poor response rates to the computer survey by planning council members (9.24 percent) limits the study’s generalizability. The study did not attempt to explain variation in the planning councils nor how differences in planning councils could explain the degree of varying influence by the planning councils? The current research will seeks to explain the council differences in activity levels, how councils differ and what the differences are? Finally, do different actions lead to different outcomes?

In conclusion, the history of mental health policy in the United States is littered with fragmented and sometimes contradictory policies. Additionally, the history of citizen participation has been fraught with abuse, discrimination and disenfranchisement in many policy areas, including mental health. The Mental Retardation Facilities and Community Mental Health Centers Act of 1963, the State Mental Health Services Plan Act of 1986 and the parallel

consumer movement have strengthened this often neglected population, but there continues to be much room for improvement. The Community Mental Health Block Grant's mandated citizen participation requirement on the Mental Health Planning and Advocacy Council is a legitimate vehicle to study the effects of citizen participation on state mental health policy in the following sections.

## Chapter 4

### Methodology

This research is concerned with citizen participation and the influence that it has on state mental health policy. The focus of this research will look at the citizen participation component of the Mental Health Planning and Advisory Councils (MHPAC) within the Community Mental Health Services Block Grant and their impact on state mental health care.

### Research Questions

This research focuses on the activity level of the Mental Health Advisory and Planning Councils of the fifty states ( plus the District of Columbia) with regards to their core mission of “monitoring, advocating and evaluation” of individual state mental health systems and the level of “influence” these activities exert on mental health policy. As a result, the research will test two main questions: First; is there variation in activity levels by Mental Health Planning and Advisory Councils among the fifty-one states? If there is, what explains the variation in activity level? Second; do differences in activity levels of MHPAC’s explain variations in mental health outcomes?

### Research Design

To investigate these questions, this research will examine state level data over the four year period 2008 – 2011. States annually submit information about the Mental Health Planning and Advisory Councils (MHPAC) as mandated by the Community Mental Health Services Block Grant. All fifty U S states, as well as the District of Columbia, will be examined from the federal fiscal years 2008 thru 2011. The information for all this data can be found at the Web Block



Grant Information System (<https://bgas.samhsa.gov/>); which is a federal website administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) branch of the Department of Health and Human Services Department (HHS). Earlier years are not accessible on the website.

For question one, this research will examine the Mental Health Services Block Grant submission of state mental health plans and implementation reports for the 50 states (and D. C.) for variation in activity levels. To answer the second question, information regarding the influence of the MHPAC, this research will use data from the National Outcome Measures that is available from the Uniform Reporting System (URS). The Uniform Reporting System is an attempt by the federal government's Substance Abuse and Mental Health Administration (SAMHSA) to compile uniform mental health outcome measures for all the states, Washington, DC and U. S. territories.

Planning councils (MHPAC) are operational in each state, Washington, DC and U. S. territories. The Community Mental Health Services Block Grant mandates annual submission (until FY 2012 when it became biennial) of state mental health plans and implementation reports regarding state progress (on previous year's state plan). These plans and reports provide significant data and ultimately insight into council activity (and influence) on state level mental health policy.

Activity levels of the MHPAC are the focus of question one and an **Activity Level Index** was developed to measure this dependent variable. The mandatory submission of each mental health state plan serves as the source for this dependent variable. To answer the second question; multiple outcome measures serve as dependent variables to measure the level of

influence of the state planning councils. These outcome measures are part of the National Outcome Measures (see above). These dependent variables are explained in the following section.

### Dependent Variables

#### Index of Mental Health Planning and Advisory Council Activities

Question one will be operationalized with the dependent variable related to activity level. An **Activity Level Index** was created by classifying the various activities planning councils could undertake. For example, councils could vary the number of annual meetings they hold (by state), the number of different state level subcommittees or panels council members attend, conferences attended, training sessions conducted, educational campaigns engaged in, evaluations, reports presented or testimony given to the state legislature (and governor). They could also hold legislative ‘hill’ days, collaborate with other state agencies, meet with members of state mental health authority, disseminate information, sponsor public meetings or hearings, complete a state plan and implementation report letters. As a result of successful completion of baseline activities by the MHPAC, federal funding of the CMHBG continued without interruption to each state during this time frame.

The **Index** utilizes twelve different activities that will be categorized into three levels of activity: low, medium and high. These three different levels are gleaned from the ten different activities and adding them up to arrive at an activity level by state for each year. Low activity is indicated by doing the minimum required for block grant compliance for three core activities. The **Index** starts from a position that each state council did the required minimum because each state submitted a state plan and an implementation report each of the four years under

study. The minimum would be defined as at least one MHPAC meeting per year (but usually quarterly), submitting both an annual state plan and implementation report letters. Moderate activity could range from four to twelve activities. The highest level of activity is defined as conducting thirteen activities and above. The council activities were gleaned from the annual state plans and implementation reports. For any specific activity measure a council did not place in the written report; the assumption is that the council did not conduct the activity.

As noted above, the index uses twelve measures to rate planning council activity levels. Below are a list of the twelve measures and how they are operationalized. These twelve activities will be combined to create a summary score for each state for each state from 2008 - 2011.

Table 4.1 MEASURES USED IN THE ACTIVITY LEVEL INDEX

MTG	The number of annual meetings a council has to evaluate the state plan and implementation reports. The meetings number will range from 0 – 12. Low=0-2, Moderate=3-8 and High=9+.
AIR	Implementation report reviewed and letter submitted. This will be coded 0 or 1. zero means not submitted with and one meaning submitted.
ASP	Annual state plan reviewed and letter submitted. This will be coded 0 or 1. Zero means not submitted and one meaning submitted.
SUB	Subcommittees that planning council members participated that were related to mental health issues within the state. These activities were in addition to the primary charge of the council related to the state plan and implementation reports. This could range from zero to the actual number attended. Low=0-3, Moderate=4-7 and High=8+.
CONF	Conferences council members attended related to mental health issues. This could range from Low=0-1, Moderate=2-5 and High=6+.
TRNG	Training that council members attended or conducted. Training could range from zero to the actual number attended. Low=0-1, Moderate=2-5 and High=6+.
EVAL	Evaluation includes any evaluation process undertaken by the council of the state mental health system on a state, local or specific program level. This could range from zero to the actual number undertaken. Low=0, Moderate=1-2, High=3+.
ADV	Advocacy includes any action undertaken by the council related to collaboration or attendance on community coalitions to promote the mental health system. This could range from zero to the actual number undertaken. Low=0-1, Moderate=2-4, High=5+.
EDUC	Statewide educational campaigns; including collaborative efforts between agencies. This could range from zero to the actual number attended. Low=0-1, Moderate=2-5 and High=6+.
SMHA	Direct contact with state mental health authority in meetings. This could range from zero to the actual number of direct contacts highlighted in state plans. Low=0-1, Moderate=2-5 and High=6+.
ISS RP	Submit reports to state mental health authority, legislative branch and/or executive branch. This could range from zero to the actual number of reports issued. Low=0-1, Moderate=2-5 and High=6+.
LEGIS	State capitol 'hill' days, direct testimony to legislative and/or executive branch. This could range from zero to the actual number of direct contacts. This could range from zero to the actual number of direct contacts highlighted in state plans. Low=0-1, Moderate=2-5 and High=6+.

The above raw numbers will lead to a total index number abased upon the total council activity level. These activities will be added and lead to an overall index score that will range

from Low 0-10=1, the middle scores ranged from 11-17 =2 and the highest category ranged from 18+=3. The formula used to create the index is:

(MTG+AIR+ASP+SUB+CONF+TRNG+EDUC+EVAL+ADV+SMHA+ISSREP+LEGIS).

For example, comparing the states of Maryland and Idaho for Fiscal Year 2010 leads to the following outcomes:

- Idaho had 4 MTG, 1 AIR, 1 ASP, 4 different SUB (assumed met one time) or 4 total SUB, 0 CONF, 0 TRNG, 3 EVAL, 1 ADV, 0 EDUC, 0 SMHA, 0 ISS RP and 1 LEGIS. This compilation results in  $4+1+1+4+3+1+1=15$ . Thus, Idaho had an activity level score of 15. This would be considered a moderately active council.
- Maryland had 12 MTG, 1 AIR, 1 ASP, 4 SUB, 1 CONF, 0 ISS REP, 6 TRNG, 1 EVAL, 1 ADV, 0 EDUC, 12 SMHA and 1 LEGIS. The resulting score would be as follows:  $12+1+1+4+1+6+1+1+12+1=40$ . Maryland had an activity level score of 40. Maryland had a highly active planning council.

### National Outcome Measures

To answer the second research question, “Do differences in activity levels explain variations in mental health outcomes?” This research will use the National Outcome Measures (NOMS) as the dependent variable. The NOMs seek to track and measure outcomes for people in recovery from mental health and substance abuse disorders. The NOMs are an effort by the federal government to create an accurate and up to date national depiction of the mental health system. The NOMS collects data regarding three broad areas or categories: mental health services, substance abuse treatment and substance abuse prevention.

The current research is only concerned with the mental health services due to focus upon state level mental health policy and citizen participation. There are various federal substance abuse block grants that require state level data reporting for the NOMS regarding substance abuse treatment and prevention; however this research will not examine that data.

The NOMS are annual outcome measures that each state must report to SAMHSA so they may compare block grant data by state. The NOMS are analyzed as a part of the Uniform Reporting System. The Uniform Reporting System collects aggregate data that describe the characteristics of people served by the state mental health authority (SMHA) on an annual basis by treatment setting, service types, performance indicators and outcome measures that support the use of the Community Mental Health Services Block Grant. This reporting system utilizes voluntary standardized reporting of State mental health data. However, different states are in different phases of implementation and every state does not report every variable in each of the ten domains. Systems issues (budget issues, lack of priority), collection methods (different methods) and state capacities (information technology infrastructure) lead to variations in reporting by the states.

The mental health NOMs collect data across ten different domains that include housing stability, cost effectiveness, perception of care, reduced morbidity, employment/education, crime and criminal justice, social connectedness, access/capacity, retention and use of evidence-based practices. This research will look at five outcome measures related to utilization rates, consumer survey results, homelessness and the total number of implemented evidence based practices.

This research will operationalize these outcome measures and utilize them as dependent variables as follows:

- ***Service utilization rate*** is number of consumers served by the mental health system in a given state. This is reported per 1,000 in state population on the URS.
- ***Consumer survey results*** are administered by the state mental health authority and

gauges client satisfaction with the actual services received. This is done in both inpatient and outpatient settings. This is reported by states as a percentage. For example, Nevada clients provided 63.1% positive survey results in FY 2011.

- **Homelessness** can be defined as not having a stable place to live. Many homeless mentally ill adults live on the streets or at a homeless shelter. For example, the homeless rate in Nevada for FY 2011 was 8.5%, which was approximately 2.5 times the U. S. national average of 3.1%.
- **Evidence Based Practices** are treatments that research has shown will work effectively with the mentally ill population. There are seven evidence based practices for the adult severely mentally ill. Every state has implemented at least one EBP, but none have implemented them all due to the voluntary nature of the MH block grant. Additionally, the cost associated with implementation of many of these EBP's includes adequate staff, training, funding priorities and the necessary corresponding infrastructure changes that would be required.

#### Hypotheses:

As noted previously; two fundamental questions exist for this research:

##### Question # 1

Do MHPAC's actively participate in mental health policy across the fifty states (& Washington, DC) and is there variation?

##### H 1

*Planning councils (MHPACs) differ in their level of activity.*

The hypothesis theorizes that the states are not alike. Some states are bigger than others, while others are small in terms of geography. Others states have populations that are more

rural than urban. Given differences in socioeconomic and environmental characteristics of the states, we would expect that mental health outcomes do differ. States will spend different amounts based upon many factors that shall be described below. For example, Nevada (“low spender”) consistently spends less on mental health and social programs. This leaves Nevada near the bottom of nearly every social indicator evaluated such as higher suicide rates, higher teen pregnancy and lower per capita spending on mental health. “High spender” states such as Massachusetts tend to have lower suicide rates, teen pregnancy and higher per capita mental health funding. Planning council (MHPAC) activity levels should play a role and this research seeks to investigate this.

- H 1.1

*The higher the percentage of citizens on the planning council in relation to state employees; the greater the activity level.*

The block grant requires a minimum percent of private citizens to be on the councils. The composition requirement per federal mandate is that “at least” fifty percent private citizens on each MHPAC. The fifty percent threshold pertains to the percentages of private citizens to government employees on the council. In this situation, we would expect the council to be more active if there was greater private citizen composition. More private citizens would offset the inability or unwillingness of state employees to be strong advocates. State employees have to balance their responsibility to the council and their employer. Increased advocacy by state employees could lead to increased costs to states. In addition, more advocacy by state employees could imply that the state was not doing enough for mental health and have a negative public relations effect. These figures will be compiled and analyzed for each state council from 2008 – 2011. The names, contact information and particular category of council



representation are included with each state plan. Specific council compositions can be found in the mental health state plan of each state under the heading State Mental Health Planning Council Requirements, Table 2; Planning Council Composition.

- H 1.2

*The more urban a state is, the more active the planning council.*

Urban states have a higher concentration of citizens surrounding major cities. Rural states are characterized by less population density spread over large distances when compared to urban states. This research will argue that urban states are more influential in making demands, so should have more council activity due to proximity, potential for accessibility and increased population density to mental health decision makers. Urban areas will likely carry more weight due to the sheer volume of constituents than rural areas. Rural state areas tend to be less populated and dispersed over a much wider land area. U S Census 2010 Urban and Rural Classification and Urban Area Criteria at

<http://www.census.gov/geo/www/ua/2010urbanruralclass.html>.

- H 1.3

*The larger the Mental Health Block Grant funds as a percentage of total state mental health budget; the more active the planning council.*

The larger the block grant's role in providing mental health services, the greater the level of importance to the overall state mental health budget. As a result, the MHPAC will have more influence over prioritizing and general control of the block grant initiatives. This information can be found in each state plan MOE and SAMHSA's annual budget (chart) under Community Mental Health Services Block Grant (SAMHSA.GOV) allotment by state.

- H 1.4

*States that have a larger percentage of mental health patients have a more active planning council.*

Percentage of mental health patients in a state related to the overall state population. Once this number is defined, one can extrapolate the percentages that receive treatment out of the overall total based upon epidemiology studies. This is due to increased demand, advocacy efforts by family or third parties and the likely recognition that it is a problem that the state needs to address. This information can be found in each State mental health plan under the heading Epidemiology.

- H 1.5

*The more conservative a state's ideology, the less active the planning council.*

State political ideology ranges from liberal on the left, conservative on the right and libertarian on the far right. Liberal views correspond with greater government intervention and a wider scope. Conservatives are for limited government and lower taxes. Libertarians are for even more limited government and lower tax rates.

Conservative states will have less active planning councils. This could be viewed as an intervening variable. The more liberal a state (with regards to political affiliation of the state legislature and governor), the more active the planning council would be. This would be due to an increased receptiveness to social programs and government involvement in these programs. Richard C. Fording's data set at <https://rcfording.wordpress.com/state-ideology-data/>.

- H 1.6

*The higher the rate of uninsured the lower the activity level of the planning councils.*

The percent of a state population that is without medical insurance, the less active a council will be. This is due to the fact that the uninsured are more likely to access other services.

- H 1.7

*The higher the poverty rate the lower the activity level of the planning councils.*

The higher the poverty level in a given state, the less active the council. This is due to the fact that those in poverty are more likely to be accessing other services. As a result, other services are meeting their needs.

To test these hypotheses, the research will create a model using a logit regression analysis related to the activity level index. This analysis is called a Multinomial regression analysis because there are more than two categories that need to be analyzed. The formula for this analysis will be:  $LOA = CPC + RPC + URB + MHF + MHC + SID + UNIN + POV$ .

Table 4.2 MULTINOMIAL REGRESSION FORMULAS BY LEVEL OF ACTIVITY

The following table highlights the above mentioned model:

<b>LOA</b>	Refers to the Level of Activity by the mental health planning council. LOA will range between low, moderate and high levels of activity.
<b>CPC</b>	Represents the percentage of private citizens on the planning council in relation to state employees. Mandates at least 50 percent of private citizens by MHBG. 1=50%. A score greater than 50% will correspond with a value greater than 1. For example, .60=1.2, .40=.8.
<b>RPC</b>	Represents composition of citizen representatives (excluding state employees). Percentages will include the at least 50% of citizens required by the MHBG. Percentages will be added to equal 1. Categories include ex patients/consumers, family members of severely mentally ill adults, family members of severely emotionally disturbed children, non-state agencies and others.
<b>URB</b>	Represents the classification of a given state as urban vs rural. Urban states will be coded as 1 and rural as 0.
<b>MHF</b>	Percentage of total state mental health funding that MHBG represents. $MHBG / \text{Total State MH funding} = \text{percentage of MHBG}$ .
<b>MHC</b>	Total percentage of mental health clients in a given state. This number is derived from the total number of mentally ill/total population in the state.
<b>SID</b>	Level of state political ideology. This will be defined as either conservative or liberal/progressive. D=Democratic or 1, R=Republican or 0.
<b>UNIN</b>	Percent of uninsured in a state. This will be defined as a percentage.
<b>POV</b>	Percent of residents living in poverty. This will be defined as a percentage.

## Question #2

Do planning council activity levels impact state mental health outcomes? Outcome measures for hypotheses related to this question will come from the Uniform Reporting System that utilizes the National Outcome Measures associated with mental health at <http://www.samhsa.gov/dataoutcomes/urs/>.

- H 2

*Differences in planning council activity levels will be associated with differences in mental health outcomes.*

Increased planning council activity levels lead to improved mental health outcomes. This is due to the likelihood that increased activity level will lead to more influence in guiding state level mental health policy and result in more positive outcomes. Outcome measures will come from the Uniform Reporting System that utilizes the National Outcome Measures associated with mental health.

- H 2.1

*Greater council activity levels lead to higher the utilization rates or numbers of consumers served in the community; at state hospitals or private facilities within the state.*

Higher council activity levels would lead to greater promotion of getting the right services to those who need it. A higher utilization rate means that more people with mental illness are actually able to receive services. This research looked at the 2010 U S Census data to extract total population in each state and compare this number with numbers and percentage of mentally ill that utilized services. The latter numbers are derived from each NOMS section on

Utilization rates on the URS. This research is concerned with adults only, but it is worth noting that there is a child estimate in each state plan. This is important because typically less than half the individuals that need mental health services are able to receive them.

- H 2.2

*Greater council activity levels lead to more positive results on the consumer surveys.*

The higher the survey results will correlate with increased patient satisfaction. Increased council activity leads to increased patient advocacy that result in higher satisfaction rates amongst clients who have contact with the system. This is important because patient satisfaction will lead to a higher likelihood of treatment compliance, increased quality of care, access to services and less usage of more costly forms of treatment such as inpatient hospitalization.

- H 2.3

*Greater planning council activity levels lead to less homelessness.*

Increased activities by planning councils promote greater advocacy for homeless type programs and result in less homelessness. Advocacy by the council leads to increased supportive housing options for this population. Homelessness among the mentally ill is pervasive and does not lead to other positive treatment outcomes. The homeless are more likely to be less medication compliant, follow up with routine medical concerns, be gainfully employed and become incarcerated.

- H 2.4

*Greater planning council activity levels lead to a higher number of implemented evidence based practices.*

There are currently seven evidence based practices for adults recognized by the NOMS. These best practices are recognized as beneficial because they have been rigorously tested to work. The higher the number of implemented best practices a state has; the healthier mentally ill adults will be.

To test the second question, an analysis of variance (ANOVA) will be conducted related to mental health outcome measures for three of the NOMS (service utilization, homelessness and consumer satisfaction surveys). The fourth NOM (evidenced based practice) will utilize the poisson regression due to the categorical nature of this variable. The independent variable will be level of activity of the planning councils. This difference of the means test will look at two different sums of squares related to outcome measures. First, the between group sum of squares that represents the total variation between the different groups and the mean. Second, the within group sum of squares will look at variation between members of the groups and their local means. The following table explains these dependent variables:

Table 4.3 NATIONAL OUTCOME MEASURE DEFINITIONS

<b>SUR</b>	Service utilization rates or numbers of consumers served by the mental health system. This number will be a percentage of total service access by the mentally ill in each state.
<b>COS</b>	Consumer surveys provide an overview of how satisfied those mentally ill clients are with the services they have received in a given state by the mental health system.
<b>HOM</b>	Percentage or numbers of homeless mentally ill. Homelessness can be defined as those without suitable stable housing. Housing is a leading indicator in ongoing treatment compliance and stability in the community.
<b>EBP</b>	Evidence based practices indicate a state commitment to provide effective services in the most efficient means possible. There are six evidence based practices for the adult severely mentally ill. The range of implementation for the treatment services range from 1 – 5 within a given state.

In conclusion, this research will utilize data collected from two separate federal level data sets for analysis of the two primary dependent variables. First, the state plans and implementation reports submitted by the states to the federal government (as required for the Community Mental Health Services Block Grant) will be utilized to quantify MHPAC activity levels over a four year period. Second, the National Outcome Measures will be utilized to measure degree of influence of the planning councils on state mental health.

## Chapter 5

### Results

This research looked at 51 Mental Health Planning and Advisory Councils (the 50 states and the District of Columbia) to determine their activity levels over a four year: 2008-2011. The 51 Mental Health Planning and Advisory Councils (MHPAC) are expected to be active in the monitoring and evaluation of the state mental health system as a condition for continued funding related to the federal Community Mental Health Block Grant. As noted previously, the source of information for the activity levels was the annual mental health state plans for each state. This analysis resulted in the creation of 12 different categories of activity. To best capture the variation of among the states for the 12 items; an Index of MHPAC Activity was created. (Please see the Methods section in Chapter 4 for further explanation of the specific activity levels that comprise the Activity Level Index).

The four year period yielded a total of 204 cases (51 cases over 4 years). However, there were 6 missing cases, resulting in 198 valid cases. The original coding schemes for the 12 items had a wide range of variation within and across the states over the four years (see Appendix 1 for the actual original values for each of the 12 elements for each state by year). For example, the original score for the activity meetings ranged from 0 – 58 (See Appendix 1). Table 5.1 provides information on all the transformed components of the Activity Level Index. The original Activity Level Index data set ranged from 3-24 for the 12 elements.

A decision was made to recode the variables because of the wide variation in scores and a desire to not weight one activity over another. For example, there was a range of Activity Levels of 58 for meetings and 11 for subcommittees (see Table 5.1). Additionally, the



regrouping was necessary because the measures were not easily comparable with the existing structure and had outliers. This researcher recognizes the regrouping of each activity and the resulting index score reduces the range of possible scores; however, it creates more comparable measures and thus is the preferred way to analyze the data. Each of the 12 Activity Level components were recoded and compiled to come up with a new Activity Level score. As a result, the higher the Activity Level Index score, the more active the MHPAC. The converse is also true; the lower the Index scores the less active the council during a particular year.

A decision was made to transform each of the activities into a categorical measure. For three of the activities, the scores could be either 0 or 1 because the activity was either completed (1) or not (0). The remaining nine variables could be scored a 0, 1 or 2. A score of zero equaled zero for an activity, a one was low and a two showed the highest activity levels. The transformed scores could have theoretically resulted in an index that ranged from 0 – 21, but actually the scores for the 198 cases ranged from 3-21. Next, these Activity Level Index scores were broken down roughly into thirds. The lowest category ranged from 0-8=1, the middle scores ranged from 9-12 =2 and the highest category ranged from 13-21=3. The last column highlights how these elements were recoded for ease of interpretation. The range of scores for Implementation Reports and State Plan completion was either a 0 or a 1. A 1 meant that the item was completed. To further illustrate the grouping rationale, the following examples will provide an overview. Meetings had 0=0, 1-4=1 and 5- the highest=2. The ranges were split into thirds. Trainings had 0=0, 1-2=1 and 3-highest=2. This was based on roughly splitting each activity into thirds based upon a variable's frequency distributions. A final example, Issue Report was coded as a 0=0 and a 1-highest=1 vs 0, 1 and 2 because there was so

little activity for this item within the states over the 4 year period being studied. A vast majority of states did not complete this item at all.

Table 5.1 INDEX TRANSFORMATION

ACTIVITY	ORIGINAL RANGE	NEW SCORES
IMPREPORT	0 – 1	0=0, 1=1
STATEPLAN	0 – 1	0=0, 1=1
MEETING	0 – 58	0=0, 1-4=1, 5-highest=2
SUBCOM	0 – 11	0=0, 1-4=1, 5-highest=2
CONF	0 – 7	0=0, 1=1, 2-highest=2
TRAINING	0 – 57	0=0, 1-2=1 and 3-highest=2
EDUC	0 – 19	0=0, 1-2=1 and 3-highest=2
SMHA	0 – 52	0=0, 1-2=1, 3-highest=2
EVAL	0 – 21	0=0, 1-2=1, 3-highest=2
LEGIS	0 – 13	0=0, 1-2=1, 3-highest=2
ISSREPORT	0 – 10	0=0, 1-highest=1
ADVOCACY	0 - 26	0=0, 1-3=1, 4-highest=2

- Original range of each activity and the resulting transformed Activity Level Index score breakdown.

Looking at the percentages that comprise the Activity Level Index; differences are seen in the activity levels across the 12 items. The information that is presented in Table 5.2 is the recoded measures used to create the final Activity Level Index. Table 5.2 shows each of the 12 State MHPAC Activities in percentages over the 4 year period being studied. Looking at Table 5.2 one can see that 70 percent of the cases did not complete Issue Reports (IR2). On the other hand, State Mental Health Administration involvement showed an even distribution for 0=30%, 1=36% and 2=33% across the 198 cases. Some activities had little or no activity on the same measure while others had substantial activity levels. For example; Conference, Education, Legislative and Issue Reports had very little activity over the 4 year period studied. Over the four year period, 66 percent of the cases did not have any conferences, 69 percent of the cases

did not have any educational activities, 61 percent did not have any legislative interactions and 70 percent did not have any issue reports submitted. On the other hand, there were other index measures where there were substantial differences in activity. For example, 94 percent of the cases had at least one meeting while 48 percent of the states had the highest level of activity. The Evaluation measure was fairly evenly distributed between 0 – 2; with 0=35% (low), 1=34% (moderate) and a 2=31% (high). Evaluation is any type of evaluation of the state mental health system that the planning council engaged in (please see Methods section for specifics).

Table 5.2 DISTRIBUTION OF THE REVISED TWELVE MHPAC ACTIVITIES (%):2008-2011

<b>Score</b>	<b>Mtg</b>	<b>Sub</b>	<b>Conf</b>	<b>Trng</b>	<b>Educ</b>	<b>Mh</b>	<b>Eval</b>	<b>Legis</b>	<b>ImpR</b>	<b>StPln</b>	<b>IssR</b>	<b>Adv</b>
<b>0</b>	4%	11%	66%	44%	69%	30%	35%	61%	2%	1%	70%	17%
<b>1</b>	46%	45%	19%	19%	23%	36%	34%	33%	98%	99%	30%	48%
<b>2</b>	48%	41%	15%	37%	8%	33%	31%	6%	NA	NA	NA	35%
<b>Total</b>	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>N</b>	198	198	198	198	198	198	198	198	198	198	198	198

Table 5.3 shows the frequency distribution of the composite index scores over the four years. One can see the range of the scores and the percent of the cases that had each score.

The Activity Level Index was compiled using the following formula:

(IMP+STATE+Meet+SUB+CONF+TRNG+EDUC+MH+EVAL+LEGIS+IR+ADV). As noted previously,

the Range of scores for the Activity Level Index was from 3-20 for the 198 valid cases. The median fell at a score of 10. The table illustrates that 33 percent fell below a score of 8 and 54 percent of the cases were at or below a score of 10. Only 15 percent of the cases had a score of 14 or above. The vast majority of cases had activity levels between a 6 and 14 (78 percent). This highlights the fact that most states were in the low to moderate activity level range.

Table 5.3 FREQUENCY OF MHPAC ACTIVITY LEVEL INDEX SCORES (Regrouped Measures)

<b>TRANSALI SCORE</b>	<b>FREQUENCY</b>	<b>PERCENT</b>
<b>3</b>	1	.5%
<b>4</b>	7	3.5%
<b>5</b>	6	3.0%
<b>6</b>	14	7.1%
<b>7</b>	17	8.6%
<b>8</b>	23	11.6%
<b>9</b>	20	10.1%
<b>10</b>	19	9.6%
<b>11</b>	17	8.6%
<b>12</b>	15	7.6%
<b>13</b>	14	7.1%
<b>14</b>	16	8.1%
<b>15</b>	8	4.0%
<b>16</b>	9	4.5%
<b>17</b>	6	3.0%
<b>18</b>	3	1.5%
<b>19</b>	2	1.0%
<b>20</b>	1	.5%
<b>Total</b>	N=198	100.0%

What is not captured in Table 5.3 is the wide variation within and amongst the states over the four years. As can be seen in Table 5.4, some states had wider variations in activity levels. The following table lists examples of the range of original Activity Level Index scores that some states had over the time being studied. For example, Alabama ranged from 8 – 20 and

Washington ranged from 7 – 21. In other words, there were a number of states with inconsistent scores year over year.

Table 5.4 EXAMPLES OF WIDE VARIATION IN ACTIVITY LEVEL SCORES WITHIN SELECTED STATES

STATE	ORIGINAL ACTIVITY LEVEL SCORE
ALABAMA08	11
ALABAMA09	20
ALABAMA10	8
ALABAMA11	11
MAINE08	8
MAINE09	12
MAINE10	15
MAINE11	17
NEWHAMP08	8
NEWHAMP09	19
NEWHAMP10	13
NEWHAMP11	9
WASH08	21
WASH09	8
WASH10	10
WASH11	7

The initial analysis of the Activity Level Index led to the conclusion that a further restructuring of the data needed to be undertaken. States do not always have similar activities from one year to the next. Additionally, there was too much variation in the original data for states across years. Table 5.5 shows the regrouped Activity Level Index. The goal was to create a new variable that had fewer scores; yet maintained variation with ordinal characteristics. The cut off points for each category were based on percentages; low activity level cases equaled 34.3 percent, moderate activity level cases made up 35.9 percent, and high activity cases represented the remaining 29.8 percent. The newly transformed Activity Level Index was

recoded to 0-8=1 (low), 9-12 =2 (moderate) and 13-highest=3 (high). Table 5.5 provides the frequency distribution of the 198 cases across the 3 categories.

Table 5.5 REGROUPED ACTIVITY LEVEL INDEX

Regrouped Index Score	Frequency	Percent
<b>1</b>	68	34.3%
<b>2</b>	71	35.9%
<b>3</b>	59	29.8%
<b>Total</b>	198	100.0%

While some states had variation over the four years, other states had relatively stable levels. Table 5.6 illustrates high and low activity states for all 4 years from 2008 – 2011. There were a total of eight consistently low activity level states and seven reliably high activity level states. For example, high activity level states included Hawaii, Kansas and Massachusetts. These high activity level states scored high (3) on the activity level index over all four years studied. Additionally, examples of low activity level states included Delaware, Louisiana and Utah. These states scored low (1) for activity levels over all 4 years. This leaves the remaining 36 states over the four year period somewhere in between. Thus, of the 59 high activity cases, there were only 31 high activity level cases out of the remaining 170 cases over the four years (198 – 28=170) not captured by the seven states with consistently high activity levels. The same can be said for the low activity states; the 8 consistently low states make up 32 out of the 68 total cases in this grouping which leaves only 36 other low activity cases. There does not appear to be a geographic pattern related to the high and low activity level states. Actually in some cases, conservative states had high activity levels such as in the Mountain West (Idaho) or Midwest (Kansas). Progressive states with low activity levels included (Northeast) Vermont and

Delaware. Conservative southern states like Texas and Louisiana seem to fit in with a low activity state; as do high activity states like Massachusetts, Maryland and New Jersey. This could be a result of the state bureaucratic structure.

Table 5.6 HIGH AND LOW ACTIVITY LEVEL STATES OVER THE 4 YEAR PERIOD

<b>LOW ACTIVITY LEVEL STATE*</b>	<b>HIGH ACTIVITY LEVEL STATE**</b>
<b>Delaware</b>	<b>Hawaii</b>
<b>Indiana</b>	<b>Idaho</b>
<b>Louisiana</b>	<b>Kansas</b>
<b>Texas</b>	<b>Maryland</b>
<b>Utah</b>	<b>Missouri</b>
<b>Vermont</b>	<b>New Jersey</b>
<b>Virginia</b>	<b>Massachusetts</b>
<b>Wisconsin</b>	

\*Low activity level is defined as a an Activity Level Index (ALI) score of 1 over the 4 year period

\*\*High activity level is defined as an ALI score of 3 over all 4 years

The previous section highlighted the variation both within and amongst the states. The research was able to show wide variation in activity levels by the MHPACs among the states, the rationale behind the index formation, and the subsequent regroupings necessary for further analysis. Attention will now turn to an effort to explain this variation in Activity Levels by analyzing the independent variables to explain variation in the Activity Level Index.

When doing an advanced statistical analysis, a researcher would prefer to use a multivariate analysis such as the Ordinary Least Squares (OLS) Regression analysis. However, the OLS technique is not appropriate because of the categorical nature of the dependent variable. This section presents the results of a logit regression analysis to examine the Activity Levels (dependent variable) of State Mental Health Planning Councils and possibly explaining

variation in activity (Activity Level Index). In other words, the analysis looked at multiple hypotheses (related to the independent variables) to explain the dependent variable. A typical ordered logit analysis is used when there is ordinal level data (with the property of not having equal distance between categories, but having an order to them). As noted before, the Activity Level Index is coded 1=low, 2=moderate and 3=high.

Two different types of ordered logit analyses were utilized to examine the effects of the independent variables upon the dependent variable (Activity Level Index). The logit and gologit analyses were utilized. Traditional logit analysis assumes that the independent variable acts in a consistent manner across the multiple analyses. The first analysis as seen below (in Table 5.7) was a normal logit model. This analysis indicated that there were two independent variables that were significant at the .05 level. The coefficient for State Ideology was  $-.0035$  and for Population Urban was  $.0218$ . In other words, the more liberal a state the less active a state mental health planning council was and more likely a state was to be located in the lower category vs the moderate or high categories of activity. For the Population Urban variable; the higher the urban population of a state, the more likely the state would be in the higher grouping (higher activity level). The results from the logit analysis show the rest of the variables were not significant (see 5.7) and, as a result, we would reject the corresponding hypothesis for those variables.



Table 5.7 ORDERED LOGIT REGRESSION OF INDEPENDENT VARIABLES AND ACTIVITY LEVEL INDEX

Independent Variable	Coefficients	Standard Errors
Percent ratio citizen pro	-.5206	1.3984
Percent population urban	.0218	.0103
Percent MH Block Grant	.0137	.0196
Prevalence rate	.0498	.2071
Updated state ideology	-.0035*	.0016
Percent uninsured	-.0865	.0340
Poverty rate	.0264	.0406
Cut1	-.008	2.226
Cut2	1.635	2.230

\*Statistically significant at  $p < .05$ .

The normal logit model was limited because it assumed consistency across variables and that there was no violation of the parallel lines assumption. As a result, this researcher needed to test the validity of these assumptions with gologit because of the potential for masking of important information. The resulting analysis is different from a regular logit analysis because of the test for parallel lines. The Wald test is used to determine statistical significance with gologit. The resulting significance value is the probability of obtaining a logistic regression coefficient at least as large as that estimated from the sample by chance alone if the true effect in the population is zero. The gologit regression shows the two logit analyses. While the overall model was acceptable, the analysis showed that all seven variables failed the parallel lines test (Table 5.8).

In conducting a logit analysis, here gologit, one uses the coefficient to determine significance and direction of the independent variable's effect on the dependent variable. Typically, one then computes from the log coefficient an odds ratio for the independent

variable. In other words, one uses the odds ratio to indicate the probability of a case being in one category vs another. In the first analysis; the odds ratio shows the probability of a case being in category 1 vs category 2 and 3. The second analysis shows the probability of a case being in category 1 or 2 vs category 3. A positive odds ratio indicates the increased likelihood of being in a higher category, whereas a negative odds ratio increases the likelihood of a case being in a lower category. Interpretation of the odds ratio is based upon a one unit change in the independent variable would lead to a higher or lower probability of staying in a particular category.

The gologit analysis in Table 5.8 shows the results for all the variables: both significant and insignificant. All seven independent variables violated the parallel lines assumption. Looking at Table 5.8 one can see that the coefficients and odds ratio for both analyses. When the parallel lines assumption is violated, the coefficients and odds ratios in the two analyses are different; resulting in a change in how one interprets the effect of independent variable on the dependent variable. Even though the percent ratio of citizens on the council was not statistically significant, its coefficients may help explain the process. The coefficient of .4204 in analysis 1 and -1.4643 in analysis 2 provides important insight. In other words, the .4204 indicates that having a positive coefficient would make it more likely for a case to be in the higher categories (not in the low group). On the other hand, the -.8035 would indicate that a state would be more likely to be in the low or moderate group and not in the higher group. Thus, the percentage of citizens on the council has a complex relationship. On the one hand, it moves states from the low activity level to a higher category, but council percentages (though not statistically significant) also appear to not move a state to the highest activity level.

The first analysis in Table 5.8 had one significant variable. The variable State Ideology was the only one found to be significant at the .05 level. The coefficient for State Ideology was -.0039 and an odds ratio of .996. The odds ratio indicates that for every unit increase in State Ideology (the more liberal) there is an increased likelihood of a state being in the lower group (low=1) than in either of the higher activity level groups. All other variables were insignificant. .

The second stage grouped the 3 categories into 2 groups; low (1) and moderate (2) vs high (3). None of the variables were found to be significant in the second analysis. It should be noted that State Ideology was not significant in the second analysis (but was in analysis 1) with a coefficient of .0059 and an odds ratio of 1.0059.

The third element in the gologit analysis provides the gamma correction. As stated previously, it results in testing for violations of the parallel lines assumption. All seven variables violated the parallel lines assumption and had gamma coefficients computed. Three of the seven variables were statistically significant at the .05 level. The coefficients for these three variables were -.1167 for Poverty rate, -.7126 for SMI Prevalence and .0663 for MHBG percent. None of the three significant variables in the gamma were statistically in either of the previous two analyses. As a result, there is an increased likelihood as poverty rate increases there is an increased likelihood of being in a lower activity grouping. The same holds true for SMI Prevalence, as prevalence rate increases there is an increased likelihood of being in a lower grouping. However, the higher the percent of MHBG funding the more likely a case would be in a higher activity level grouping. Violating the parallel lines assumption likely explains the

insignificant coefficients in analysis two (Table 5.8). The other four variables were statistically insignificant in all three analyses.

Table 5.8 GOLOGIT REGRESSION ANALYSIS (WITH GAMMA) FOR ACTIVITY

<b>Independent Variable</b>	<b>Coefficients</b>	<b>Standard Errors</b>	<b>Odds Ratio</b>
<b>Percent ratio citizen pro</b>	.4204	1.6924	1.523
<b>Percent population urban</b>	.0198	.0124	1.020
<b>Percent MH Block Grant</b>	-.0453	.0346	.956
<b>Prevalence rate</b>	.4447	.2704	1.560
<b>Updated state ideology</b>	-.0039*	.0019	.996*
<b>Percent uninsured</b>	-.0727	.0422	.930
<b>Poverty rate</b>	.0867	.0514	1.091
<b>Cons1</b>	-3.9344	2.7861	
<b>Percent ratio citizen pro</b>	-.8035	1.7516	.448
<b>Percent population urban</b>	-.0209	.0136	.979
<b>Percent MH Block Grant</b>	.0210	.0233	1.021
<b>Prevalence rate</b>	-.2680	.2617	.765
<b>Updated state ideology</b>	-.0069	.0073	.993
<b>Percent uninsured</b>	-.0734	.0441	.929
<b>Poverty rate</b>	-.0300	.0498	.970
<b>Cons2</b>	.8279	2.9687	
<b>Gamma</b>			
<b>Percent ratio citizen pro</b>	-1.2239	1.9080	
<b>Percent population urban</b>	.0011	.0149	
<b>Percent MH Block Grant</b>	.0663*	.0300	
<b>Prevalence rate</b>	-.7126*	.2955	
<b>Updated state ideology</b>	.0108	.0073	
<b>Percent uninsured</b>	-.0007	.0300	
<b>Poverty rate</b>	-.1167*	.0554	

\*Statistically significant at  $p < .05$ .

The next stage of this research looks at the ability of the Activity Level Index to explain variations in mental health outcomes. In other words, variations in Activity Levels should explain differences in the mental health system outcomes of a state. The general hypothesis was that the more activity by a council the better the mental health results. Initially, an Analysis of Variance (ANOVA) was conducted (with the Transformed Regrouped Activity Level Index) as the independent variable in explaining variation in three National Outcome Measures (NOMS) used in this research for Service Utilization rates, Consumer Satisfaction and Homelessness NOMS. (Please see the Methods section in Chapter 4 for a more detailed explanation of these variables). In conducting the analysis of variance, this researcher ran a comparison of groups in ANOVA. These comparisons compared activity levels of groups: 1 vs 2, 1 vs 3 and 2 vs 3. The next step was the use of regression analysis for the above stated NOMS with a series of control variables (population urban, MHBG percent, prevalence rate, state ideology, uninsured rate and poverty rate). The Evidence Based Practice NOM utilized the poisson regression analysis due to this variable being count data.

The results in Table 5.9 A-C show that the activity level of a state has some explanatory ability for one (homelessness) of the three NOMS analyzed. Homeless Percent was statistically significant at the .000 level. However, the other two were very close to being significant. Service Utilization was at the .067 level and Consumer Surveys (.084).

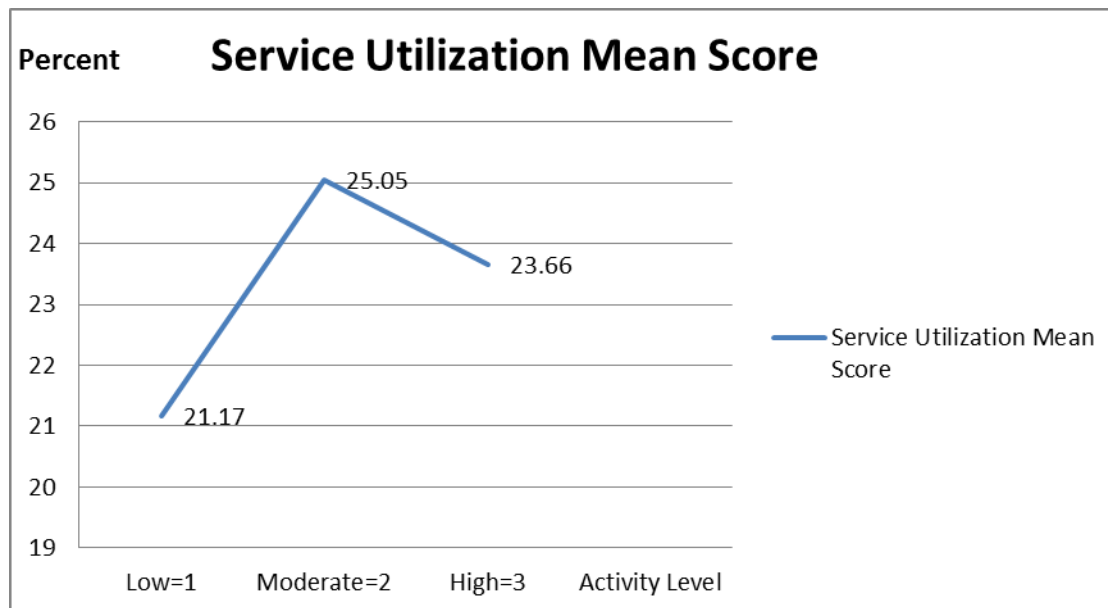
The ANOVA indicates that as Service Utilization rates go up by mental health consumers the more the more active the Councils are in addressing and/or funding this issue. The results are significant at the .067 level. The frequencies were low=68, moderate=71 and high=59. The

scores ranged from 4.22 – 47.89 with the mean for low=21.17, moderate=25.05 and high=23.66. The Tukey HSD was used to do multiple comparisons of each dependent variable. There was a significant difference at the .056 level between the low (1) vs the moderate (2) activity level. In other words, service utilization of the mental health system increases in a significantly positive direction as activity level increases from low to moderate activity. The mean plot in Figure 5.1 illustrates the significant positive difference between the low and the moderate categories (There was no significant difference between the 1 vs 3 or 2 vs 3). However, Figure 5.1 illustrates the significant positive difference between the low and moderate activity levels (21.17 to 25.05), and the downturn between the moderate and high activity levels (25.05 to 23.66). Thus, overall analyses of the three levels masks a significant shift between cases with two levels of activity vs those with medium levels of activity.

Table 5.9 A-C ANALYSIS OF VARIANCE OF 3 NOMS BY RECODED ACTIVITY LEVEL INDEX

A. SERVICE UTILIZATION				DF	F	Significance Level
Activity Index Score	N	Mean	St Error	2/195	2.74	.067
Low=1	68	21.17	1.14			
Moderate=2	71	25.05	7.80			
Highest=3	59	23.66	1.60			
Total	198	23.30	9.95			

Figure 5.1 SERVICE UTILIZATION RATE BY ACTIVITY LEVEL

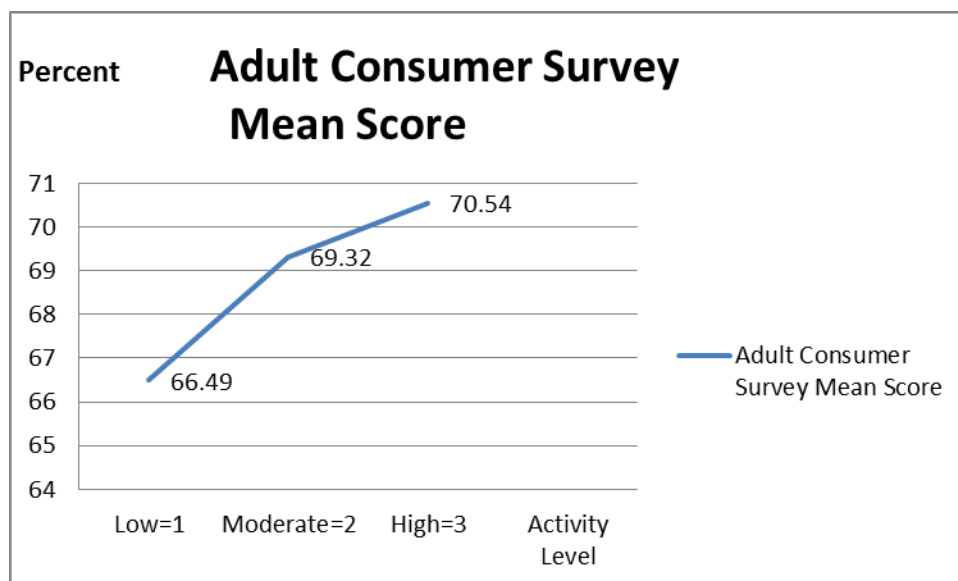


The Adult Consumer Satisfaction Survey results showed that the higher the activity level of a council, the higher the consumer satisfaction rates. This makes sense intuitively because the more activity a council engages in, the more satisfied an individual is to be with the services received. The relationship was borderline significant at the .084 level. Hence, the results were not found to be statistically significant at the .084 level. The range of consumer satisfaction rates with mental health services received was from 41.80 to 96 percent. The mean for the low activity level cases was 69.26, the moderate states were 71.74 and for the high activity were 73.12. Again, the Tukey HSD was used to make multiple comparisons of the dependent variable by the three categories of the independent variable. None of the comparisons were significant at the  $p < .05$  level. Consumer satisfaction did not show a significant increase based upon activity levels. Despite not being significant, there was a steady increase in activity levels as consumer satisfaction increased. The mean plot illustrates this steady increase in satisfaction between the

low, moderate and high activity categories. In conclusion, even though the consumer satisfaction was not found to be significant at the .084 level, there still seems to be a positive increase between increased activity level and consumer satisfaction. Additionally, because the original ANOVA was a 2 tailed test, this researcher would argue that this NOM would be significant at the .042 level in a 1 tailed ANOVA. As a result, activity levels do significantly explain differences in consumer satisfaction rates amongst the states.

B. ADULT CONSUMER SVY				DF	F	Significance Level
Activity Index Score	N	Mean	St Error	2/188	2.51	.084
Low=1	68	66.49	11.44			
Moderate=2	68	69.32	1.21			
Highest=3	55	70.54	1.28			
Total	191	68.67	.76			

Figure 5.2 CONSUMER SATISFACTION RATE BY ACTIVITY LEVEL

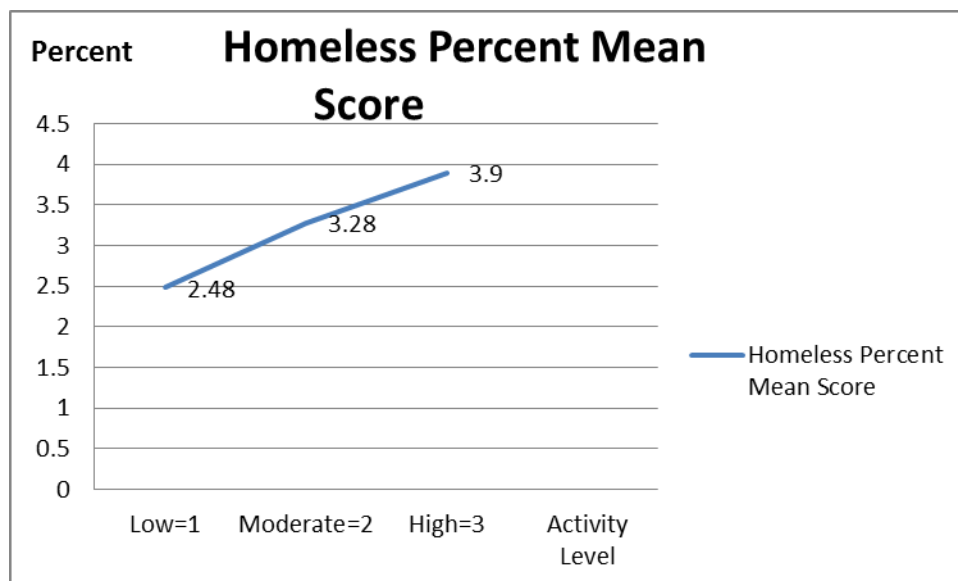




The activity level index had the greatest explanatory power for the Homelessness NOM. It was statistically significant at the .000. As a result, the higher the activity levels of a state, the higher the percentage of homeless individuals. The range was from 0 to 9 percent. The mean for low=2.48, moderate=3.28 and high=3.90. The Tukey HSD was used to do multiple comparisons of each dependent variable. There was a significant difference at the  $p < .05$  level at .000 between the low (1) vs the high (3) activity level and at .023 between the low (1) and moderate (2) activity levels. Low activity states were significantly different than the moderate and high activity states. However, the Tukey HSD shows that there was no significant difference between moderate and high activity states. While this is not the hypothesized direction, one possible explanation might be that an increased awareness of the homeless problem could lead to a corresponding increase in planning council activity levels. In addition, a state may be more urban and have a more visible homeless issue. The mean plot illustrates a consistent positive relationship between increased homelessness and activity levels.

C. HOMELESS PERCENT				DF	F	Significance Level
<b>Activity Index Score</b>	N	Mean	St Error	2/193	10.31	.000
<b>Low=1</b>	68	2.48	.18			
<b>Moderate=2</b>	70	3.28	.20			
<b>Highest=3</b>	58	3.90	.28			
<b>Total</b>	196	3.18	.13			

Figure 5.3 PERCENT HOMELESS BY ACTIVITY LEVEL



The Evidenced Based Practices implemented by each state have seven different types of practices. A decision was made to utilize the robust poisson regression for this analysis because this is count data. This analysis showed that High Activity (.057), Uninsured (.043), State Ideology (.000) and Population Urban (.001) were all significant. The high activity variable indicates that as states went from the low and medium activity levels to the high activity levels, the odds of having less Evidence Based Practices increased. For example, having an incident rate (odds ratio) of 1.10 would indicate that there is a 10 percent increased likelihood that states with high activity levels would have an increased number of EBPs. The incident ratio for this variable was .8423. In other words, the states were 16 percent more likely to implement less EBPs going from the low or medium activity levels to the high activity level. Additionally, as the uninsured rate increased there was a very small likelihood that the number of EBPs would increase. The incident rate of 1.016 illustrates that for every unit increase in the uninsured rate, there was a .02 percent chance that the number of EBPs would increase. Similar results

occurred with State Ideology incident rates at 1.0005 and Percent Urban at 1.0079. As a result, the more conservative a state was, the more likely that there would be more EBPs implemented. This result occurred with Percent Urban, too. The more urban a state was, the more likely a state would have increased EBPs. The overall model with a chi square of .000 indicates that the overall model is significant, too. The mean for low=4.37, moderate=3.77 and high=3.44. The mean plot illustrates the negative relationship that exists for this NOM.

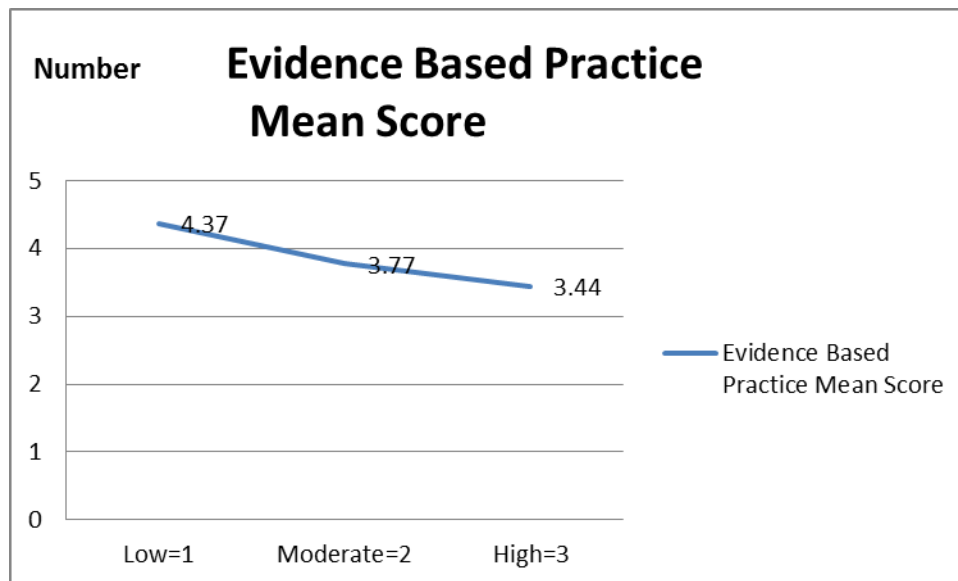
In conclusion, as activity level increases the number of evidenced based practices implemented decreased. This is not the direction that was originally hypothesized for this variable. One explanation might be the nature of the state itself in terms of being poor, the implementation of EBPs being expensive or uncertainty related to effectiveness.

Table 5.10 EVIDENCED BASED PRACTICES NOM BY ACTIVITY LEVEL USING THE POISSON REGRESSION

EBPBYSTATE	Coefficient	Robust St Error	IRR	Significance
<b>Medium Activity</b>	-.1215	.0811	.8856	.134
<b>High Activity</b>	-.1715*	.0902	.8423	.057*
<b>Poverty</b>	-.0169	.0093	.9832	.068
<b>Uninsured</b>	.0162*	.0080	1.0163	.043*
<b>Update State Ideology</b>	.0005*	.0001	1.0005	.000*
<b>SMI Prevalence</b>	.0344	.0487	1.0350	.480
<b>MHBG Percent</b>	.0008	.0055	1.0008	.882
<b>Population Urban</b>	.0079*	.0023	1.0079	.001*
<b>Constant</b>	.9036	1.1197	2.4684	.046

\*Significant at the  $p < .05$  level.

Figure 5.4 EVIDENCED BASED PRACTICE BY ACTIVITY LEVEL



The last analysis was a linear regression that utilized dummy variables due to the ordinal nature of Activity Levels. These dummy variables were created to analyze the high activity level states vs the moderate states with the reference group being low activity states. The linear regression was conducted because activity levels may impacted by the independent variables and will control for any mitigating factors present. The model incorporated several independent variables that included population percent urban, updated state ideology, poverty rate, percent of MH block grant funding, smi prevalence rate, high activity levels, medium activity levels and the uninsured rate. Overall, all four models were found to be significant at the .05 level. Service Utilization (.000), Consumer Satisfaction (.004), Homeless Percent (.000) and Evidence Based Practices (.000).

The service utilization model was found to be significant at the .000 level. This indicates the eight variables in the model had much explanatory value. Two variables were significant

that included state ideology at the .000 level and urban percent at .000. The coefficients were: state ideology (.128) and urban percent (-.223). Ideology was significant and showed that the more conservative a state was, the higher the utilization rates were of their mental health systems. This makes sense because typically these states would be poorer and is more likely to be used by the poor or disenfranchised. Lastly, the percent urban variable was significant at .000. The negative coefficient (-.223) indicates that the more urban a state was the lower the mental health service utilization rate would be. This seems counterintuitive since people are more concentrated in large cities and would have easier access to services. This researcher suspects that this negative effect may be a result of a system that is overburdened and thus urban states may have to limit service utilization. On the other hand, utilization rates may already be high comparatively speaking, so limits are placed on the mental health system due to finite financial resources.

Table 5.11 SERVICE UTILIZATION NOM BY VARIOUS INDEPENDENT VARIABLES

Variables	Coefficient	Standard Error	R square	DF	Significance Level
<b>Overall model</b>			.246	8/184	.000*
<b>Constant</b>	32.131	8.582			.000
<b>High Activity</b>	1.101	1.654			.507
<b>Medium Activity</b>	2.877	1.541			.064
<b>Poverty Rate</b>	.188	.187			.317
<b>Uninsured Rate</b>	-.202	.177			.255
<b>State Ideology</b>	.128*	.031			.000*
<b>SMI Prevalence</b>	-.655	.994			.551
<b>MHBG Percent</b>	.099	.187			.598
<b>Urban Percent</b>	-.223*	.048			.000*

\*Significant at  $p < .05$

The consumer survey model was found to be significant at the .004 level. The variables that were significant included high activity (.029) and poverty rate (.002). The coefficient for high activity was 4.278 and poverty (.695). These results indicate that the high activity states were associated with higher consumer satisfaction rates. These results are consistent with the original hypothesis that higher activity levels lead to higher satisfaction rates. The reason may be that consumers see that a state is doing a lot to assist them, so they are happy with their interactions. Lastly, the higher the poverty rate the higher the consumer satisfaction rate. This increased satisfaction on the survey by people who were in poverty could have been because they felt like they were being heard and getting the necessary services already.

Table 5.12 CONSUMER SURVEY NOM BY VARIOUS INDEPENDENT VARIABLES

Variables	Coefficient	Standard Error	R square	DF	Significance
<b>Overall model</b>			.119	8	.004*
<b>Constant</b>	47.645	10.215			.000
<b>High Activity</b>	4.278*	1.938			.029*
<b>Medium Activity</b>	3.099	1.789			.058
<b>Poverty Rate</b>	.695*	.224			.002*
<b>Uninsured Rate</b>	-.283	.206			.172
<b>State Ideology</b>	-.033	.036			.348
<b>SMI Prevalence</b>	.194	1.183			.870
<b>MHBG Percent</b>	.134	.215			.535
<b>Urban Percent</b>	.053	.056			.074

\*Significant at  $p < .05$

The homeless percent model was found to be significant at the .000 level. This indicates the eight variables in the model explained the homeless rate NOM fairly well. High activity level was significant at .001, medium activity at .041, uninsured at .003, percent MHBG at .006 and population urban at .000. The coefficients were as follows: high activity at 1.043, medium activity at .573, uninsured rate at .096, percent MHBG at .093 and percent urban at .041. As a result, all these variables explain homeless rates in similar ways. As states increase their activity levels into the high and medium activity categories, so too do homeless rates increase. These results seem counterintuitive and not the direction that was initially hypothesized. This may have to do with the nature of the state programs already in place. States may already be addressing homelessness in significant ways and decreasing homeless rates may just be too difficult to address. The higher the uninsured rate leading to higher homelessness does make

sense. These individuals would be more likely to be living in poverty or possibly unemployed, leading to increased homelessness. Also, the impact of the great recession during the time period (2008 – 2011) being studied cannot be overstated. The great recession lead to high unemployment and possibly an increase in homelessness for the severely mentally ill. The higher the percent of the MHBG also lead to a higher homeless rate. This could be a byproduct of the flexibility that the block grant offers to states. In other words, the block grant could be used to directly address the issue of homelessness because the grant was federal in nature. Finally, the higher the percent urban a state is, the higher the homeless rate. Urban states have higher concentrations of people around large cities, so it would stand to logic there would be more homeless individuals in these areas.

Table 5.13 HOMELESS PERCENT NOM BY VARIOUS INDEPENDENT VARIABLES

<b>Variables</b>	<b>Coefficient</b>	<b>Standard Error</b>	<b>R square</b>	<b>DF</b>	<b>Significance</b>
<b>Overall model</b>			.282	8	.000*
<b>Constant</b>	.615	1.550			.692
<b>High Activity</b>	1.043*	.299			.001*
<b>Medium Activity</b>	.573*	.278			.041*
<b>Poverty Rate</b>	-.047	.034			.168
<b>Uninsured Rate</b>	.096*	.032			.003*
<b>State Ideology</b>	.008	.006			.163
<b>SMI Prevalence</b>	-.213	.179			.237
<b>MHBG Percent</b>	.093*	.034			.006*
<b>Urban Percent</b>	.041*	.009			.000*

\*Significant at  $p < .05$



In conclusion, this chapter explained the activity level index, conducted a logit regression in an attempt to explain variation in activity levels, an ANOVA on three NOMs, linear regression for the same three NOMs (service utilization, consumer satisfaction and homelessness) using a dummy variable in an effort to explain differences in activity levels amongst states over a four year period from 2008 – 2011 and a poisson regression for the evidenced based practice NOM. The last chapter will discuss the conclusions and limitations to this research at length.

## Chapter 6

### Conclusions

The Federal government since the 1960's has placed conditions on state and local governments if they want to receive Federal grant dollars. In several Federal grants, one condition placed upon states is to require citizen involvement in program development and/or management. The requirement for citizen participation stems from the turmoil of the 1960's and the belief that citizen participation is an important symbolic element in a democracy. The Mental Health Block Grant requires every block grant recipient to create an Advisory Council consisting of both private citizens and state service providers. It was these Advisory Councils that serve as the focus of this research. The central question of the research sought to determine if the Advisory Councils engaged in any form of meaningful activity.

To evaluate activity, this research, used information found in a state's annual mental health plan or report that recipients had to file as part of their grant application. The initial analysis uncovered twelve activities undertaken by Councils that then could be used to evaluate Councils' activity. The twelve activities were studied and aggregated to form an Activity Level Index. The analysis of the 50 states and the District of Columbia found evidence that Advisory Councils were more than just symbolic; the Council, in fact, did carry out a variety of activities. For example, the Massachusetts Advisory Council had 52 meetings in 2011. However, not all the state Councils could be categorized as active; Nevada had few meetings (four) in 2011. In addition, some states were quite active over the twelve categories. For instance, Massachusetts was active in all twelve categories of activity in 2010, whereas Michigan had only had three activities in 2010.

The analysis of the 51 programs over the four years provides evidence that some states were consistently high while others consistently ranked low in activity and still other units were inconsistent in their activity levels over the four years of study; but all Councils carried out some activities each year.

The research next sought to explain the variation in activity for the 204 cases. Seven independent variables were hypothesized to explain variation in Advisory Council behavior. Citizen participation on the Advisory Council, as measured by the number of citizens sitting on the Council, was expected to predict a higher level of activity. Five other variables that including the more liberal the state ideology, the greater the prevalence of mental health patients in the system, the more uninsured people in a state and the more urban the state were all expected to predict higher levels of activity. The sixth variable expected to have a positive relationship was the percent of a state's funding received from the Mental Health Block Grant (MHBG) with greater activity associated with more MHBG dependence. On the other hand, a higher percentage of poverty in a state was expected to have a negative relationship with Council activity. The expectation was that a variety of services available from other agencies could address individual's potential mental health issues.

Unfortunately, six of the seven variables were not statistically significant. The only variable that was significant was a state's ideology. Interestingly, the more liberal a state the less active a council and the more likely a council would be in the lowest activity level grouping of states. This seemingly contradictory finding may be the result of liberal states having a more well-established mental health system or set of services, thereby reducing a citizen's sense that

they need to be active to ensure quality mental health services. Of the six variables that were not statistically significant, some variables operated in a complex manner with both positive and negative coefficients. For example, the percent of citizens on a council had a coefficient that was in the right direction for comparing the low activity states to the other two categories of states. The more citizens on the council the more likely a council was not a low activity state. However, the analysis also provided evidence that the council makeup operated somewhat differently when comparing the low and mid-range Councils to the highest Councils. A higher percentage of citizens reduced the probability of being a high activity state. In other words, there was a threshold and the more citizens on an Advisory Council moves the Council to the mid-level, but does not lead to movement into the highest level of activity.

Despite the limited ability to explain variation in council activity levels, the councils did differ in their level of activity. The research next sought to determine if the differences in activity level impacted a state's mental health outcomes. Using the activity level index as an independent variable, and controlling for other factors that might explain variation in outcome the analysis investigated a Council's activity level impact on four National Outcome Measures (NOMS): service utilization, consumer satisfaction, homelessness and evidence based practices.

Three of the four measures were interval and the fourth (Evidence Based Practices) was a count variable which required a different analytical technique. For the three interval level dependent variables, two statistical steps were undertaken. First, an analysis of variance (ANOVA) was conducted and then a regression analysis. The regression analysis created two dummy variables due to having three categories of activity levels; high activity (vs. low and

medium) and medium activity (vs. high and low) with the reference group as low activity level states. In addition, there were six control variables (poverty rate, uninsured rate, state ideology, prevalence rate, MHBG percent and urban percent).

For the first outcome measure, service utilization, the ANOVA did not provide any evidence that the Activity Level Index was statistically significant. However, a closer look at the data showed that there was significance between low to medium activity levels, but not high. Using the regression analysis, did not alter the findings that activity levels played no significant role in explaining service utilization rates. (However, state ideology and urban percent were significant.)

The second outcome measure analyzed was the consumer satisfaction survey. The ANOVA did not provide any evidence that the Activity Level Index was statistically significant. However, a closer look at the mean scores illustrated a clear upward trend. In other words, as activity level increased; consumer satisfaction rose. More important for the consumer survey outcome, when adding the control variables, high and medium activity councils levels were associated with higher consumer satisfaction rates. (Additionally, states with higher poverty rates were found to be associated with higher satisfaction rates.)

The third outcome measure examined was the homelessness rate. The ANOVA did provide evidence that the activity level index was statistically significant. This model was significant as a whole, although in a different direction than originally hypothesized. The homeless rate actually increased instead of decreasing based upon activity levels. In addition, there was a significant difference between the low vs the high activity levels and the low vs moderate activity levels,

not adequate for high. Low activity states were significantly different than the moderate and high activity states. There was no significant difference between moderate and high activity states. The regression analysis was statistically significant. High and medium activity levels were both significantly associated with higher homeless rates. However, this is not to imply causation because it just does not make any sense. The opposite should be true; that is as activity level increases, the homeless rate should decrease. Additionally, multiple control variables were significant (uninsured percent, percent MHBG and population urban).

The last NOM studied was the number of evidence based practices (EBPs) implemented by a state. The model was statistically significant using the poisson regression. High activity and medium activity levels were statistically significant and associated with the number of EBPs implemented. However, the association was in the opposite direction. The higher the activity level, the lower the number of EMPs implemented. This could be the result of a state already doing enough for mental health with other services, so does not view it as important and the implementation costs may be prohibitive. (In addition, the uninsured rate, percent MHBG and urban percent were all significant control variables).

### Limitations

Every research project has limitations that initially could not be identified and this project is no exception. The limitations might well be divided into those directed at understanding the level of activity undertaken by the councils and then a second set of limitations on the conclusions with regard to understanding a council's activities impact. While the research found advisory councils carried out a variety of activities, there was an inability to

fully explain the variations within and among the states. Several limitations might have figured into the results. First, the Federal government provides a template for states to report council activities, but there is neither a form nor directive on what had to be reported that would provide for uniformity in reporting. Thus, a second limitation is that a report is dependent upon the author's style including his or her sense of what should be reported. Not only does this possibly explain variations across states, it might well explain variation within a state. A third limitation rests with the fact that councils do not stay constant and differences in council composition might lead to differences in priorities: activities. There was no way of knowing the thinking of a council in developing the report. In addition, there is no prescribed training for all council members and that could impact how council operated and reported their activities. A fourth limitation in the reporting of activities rests with the time given to council members to prepare their report that had to be part of a state's grant application. If a state mental health agency did not respect the Advisory Council, the agency might not share the grant application in sufficient time for serious interaction with its Council to permit a thorough advisory council report.

At least four possible factors may have limited the impact councils had on outcomes. First, the activity of a council is merely advisory and not authoritative. It is possible that the process and the outcomes would be quite different if the planning council actually had control over the programs and the funding. The priorities may shift given the citizen perspectives inherent on each Council. There were multiple state plans and state plan letters produced by a Council listing concerns and advocating for budgetary changes for different programs. Second, at the same time the block grant requires a planning council to produce a plan and a report,

states are under federal court requirements to resolve issues from the Olmstead decision. The Olmstead decision was more far-reaching and impactful to a state than the block grant requirements. A state does not want to have a lower federal court conclude that it has not complied with the Supreme Court's direction and possible sanctions. Moreover, the Olmstead decision required states to be involved in a whole host of initiatives from housing to transportation. This research did not try and understand the dynamics that might be involved by mental health agencies with regard to the interaction between the councils block grant reports and the Olmstead plans. Third, time might be a factor. In other words, there might be a significant gap between what is recommended and what actually occurs. The relationship between activities and outcomes might take longer than the time horizon in this study. Finally, and perhaps most important, the assumption that the advisory council reports lead to significant policy changes may overstate the role of citizen participation. The impact of citizen participation might be subtle; for example, the council's impact might be reflected in how mental health agency officials interact with citizens or transfer information rather than policy changes.

To resolve some of these limitations, future research could involve an in depth case study of a highly active state vs. a low activity state. This case study could look at the different processes that go into the state plan write up with specific attention to the differences between a high and low activity state. In other words, what do high activity states do that low activity states don't? A case study could involve a single year or multiple years of a single state. In addition, interviewing council members or conducting a survey may assist further in explaining the activity level process by adding a qualitative component to Council responsibilities. Lastly,



there may be different variables that need to be studied that this research did not capture; a survey may tease this out.

In conclusion, there is quite a bit of variation by state mental health planning councils. Additionally, Councils serve as an important function in the evaluation, advocacy and review of each state's mental health system. The Council is a primary link between the state and the federal government in block grant systems. Leverage can be utilized by the federal government when issues arise to promote change. The explanation as to why there was such variation needs further research as stated above. Activity levels and influence really depend upon the relationship between the planning council and the state mental health authority due to the lack of decision-making authority. It appears that Councils do make a difference (if not always in the predicted ways) and are not merely symbolic. Citizen participation on advisory councils appears to promote advocacy for populations in need. However, training of the Councils and increased oversight by the federal government may assist the Councils meet their goals in a more efficient or effective manner. As a result of this research, we can conclude that federal requirements for citizen participation in block grants do encourage citizens to be active in mental health policy making at the state government level.

# APPENDIX 1

STATE	ORIGALI	TRANSGRP	STATE	ORIGALI	TRANSGRP
ALABAMA08	11	2	HAWAII09	15	3
ALABAMA09	20	2	HAWAII10	15	3
ALABAMA10	8	1	HAWAII11	14	3
ALABAMA11	11	2	IDAHO08	19	3
ALASKA08	0	2	IDAHO09	16	3
ALASKA09	14	2	IDAHO10	17	3
ALASKA10	15	2	IDAHO11	17	3
ALASKA11	10	1	ILLINOIS08	10	2
ARIZONA08	13	2	ILLINOIS09	9	2
ARIZONA09	12	2	ILLINOIS10	10	2
ARIZONA10	7	1	ILLINOIS11	8	1
ARIZONA11	10	2	INDIANA08	6	1
ARKANSAS08	11	2	INDIANA09	6	1
ARKANSAS09	13	2	INDIANA10	6	1
ARKANSAS10	15	3	INDIANA11	8	1
ARKANSAS11	13	2	IOWA08	13	2
CALIFORNIA08	12	2	IOWA09	11	2
CALIFORNIA09	13	3	IOWA10	14	3
CALIFORNIA10	14	3	IOWA11	18	3
CALIFORNIA11	15	3	KANSAS08	17	3
COLORADO08	5	1	KANSAS09	18	3
COLORADO09	24	1	KANSAS10	17	3
COLORADO10	0	2	KANSAS11	17	3
COLORADO11	5	1	KENTUCKY08	10	2
CONNECT08	10	2	KENTUCKY09	13	2
CONNECT09	10	2	KENTUCKY10	15	3
CONNECT10	18	3	KENTUCKY11	15	3
CONNECT11	15	3	LOUISIANA08	8	1
DELAWARE08	4	1	LOUISIANA09	7	1
DELAWARE09	4	1	LOUISIANA10	8	1
DELAWARE10	4	1	LOUISIANA11	7	1
DELAWARE11	4	1	MAINE08	8	1
DISTRICTOFC08	13	3	MAINE09	12	2
DISTRICTOFC09	11	2	MAINE10	15	3
DISTRICTOFC10	11	2	MAINE11	17	3
DISTRICTOFC11	11	2	MARYLAND08	19	3
FLORIDA08	10	2	MARYLAND09	17	3
FLORIDA09	12	2	MARYLAND10	15	3

FLORIDA10	13	2	MARYLAND11	16	3
FLORIDA11	16	3	MASS08	17	3
GEORGIA08	10	2	MASS09	21	3
GEORGIA09	8	1	MASS10	21	3
GEORGIA10	10	2	MASS11	19	3
GEORGIA11	10	2	MICHIGAN08	8	2
HAWAII08	15	3	MICHIGAN09	15	3
MICHIGAN10	3	1	NORTHDAK08	13	2
MICHIGAN11	10	2	NORTHDAK09	7	1
MINNE08	15	2	NORTHDAK10	9	1
MINNE09	9	2	NORTHDAK11	10	2
MINNE10	16	3	OHIO08	11	2
MINNE11	11	2	OHIO09	9	2
MISSI08	99	99	OHIO10	9	2
MISSI09	99	99	OHIO11	7	1
MISSI10	10	2	OKLAH08	7	1
MISSI11	18	3	OKLAH09	9	2
MISSOURI08	19	3	OKLAH10	10	2
MISSOURI09	19	3	OKLAH11	11	2
MISSOURI10	20	3	OREGON08	14	3
MISSOURI11	17	3	OREGON09	12	2
MONT08	7	1	OREGON10	18	3
MONT09	9	2	OREGON11	13	2
MONT10	10	2	PENNSYL08	4	1
MONT11	10	2	PENNSYL09	11	2
NEBRASKA08	14	3	PENNSYL10	8	1
NEBRASKA09	11	2	PENNSYL11	5	1
NEBRASKA10	10	2	RI08	10	2
NEBRASKA11	11	2	RI09	14	3
NEVADA08	10	2	RI10	13	2
NEVADA09	13	3	RI11	13	2
NEVADA10	15	3	SOUTHCAR08	7	1
NEVADA11	13	3	SOUTHCAR09	7	1
NEWHAMP08	8	1	SOUTHCAR10	6	1
NEWHAMP09	19	3	SOUTHCAR11	6	1
NEWHAMP10	13	3	SOUTHDAK08	6	1
NEWHAMP11	9	2	SOUTHDAK09	10	2
NEWJER08	14	3	SOUTHDAK10	8	1
NEWJER09	16	3	SOUTHDAK11	9	1
NEWJER10	16	3	TENNE08	12	2
NEWJER11	15	3	TENNE09	7	1

NEWMEX08	6	1	TENNE10	9	2
NEWMEX09	6	1	TENNE11	8	1
NEWMEX10	9	2	TX08	8	1
NEWMEX11	8	1	TX09	7	1
NEWYORK 10	10	2	TX10	7	1
NEWYORK08	6	1	TX11	7	1
NEWYORK09	8	1	UT08	5	1
NEWYORK11	10	2	UT09	6	1
NORTHCAR08	20	3	UT10	9	1
NORTHCAR09	14	3	UT11	9	1
NORTHCAR10	12	2	VERM08	8	1
NORTHCAR11	10	2	VERM09	8	1
VERM10	8	1			
VERM11	8	1			
VIRG08	5	1			
VIRG09	7	1			
VIRG10	5	1			
VIRG11	9	1			
WASH08	21	3			
WASH09	8	1			
WASH10	10	2			
WASH11	7	1			
WESTVIR 08	16	3			
WESTVIR09	12	2			
WESTVIR10	19	3			
WESTVIR11	99	99			
WISC08	7	1			
WISC09	6	1			
WISC10	6	1			
WISC11	6	1			
WY08	99	99			
WY09	99	99			
WY10	99	99			
WY11	4	1			

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## Curriculum Vitae

### **RONALD STRICKLAND, Ph.D. LCSW**

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Las Vegas, NV 89135

[Ronald.Strickland@va.gov](mailto:Ronald.Strickland@va.gov)

702-499-9682

### **SUMMARY OF QUALIFICATIONS**

Sixteen years of Licensed Clinical Social Work experience in various settings. Areas of expertise include public administration, mental health care policy on a state (and federal) level and citizen participation in the democratic process. Experience in program development, discharge planning and community referrals. Conduct biopsychosocial evaluation, DSM V diagnoses and brief treatments. Individual, family and group therapy using eclectic social work methods. Clinical supervision and case management interventions.

### **EDUCATION**

#### **UNIVERSITY OF NEVADA-LAS VEGAS**

Sept. 2007-present

Ph.D. in Public Affairs

Las Vegas, NV

Citizen participation impact within Mental Health Planning and Advisory Councils.

#### **BOSTON COLLEGE**

August 1997

M.S.W. in Clinical Social Work

Chestnut Hill, MA

#### **UNIVERSITY OF MASSACHUSETTS**

May 1991

B. A. in Psychology

Amherst, MA

### **PROFESSIONAL EXPERIENCE**

#### **SENIOR SOCIAL WORKER (detailed at CRRC)**

March 15 - Present

EMERGENCY DEPARTMENT

VETERANS ADMINISTRATION MEDICAL CTR

Provide mental health assessments; discharge planning, education and referral to Veterans. Collaborate with multidisciplinary teams to address any biopsychosocial issues that may arise. Complete Advanced Directives. Supervise a UNLV graduate social work practicum student from 9/15 – 5/16.

**RONALD STRICKLAND****-Page 2-****SENIOR SOCIAL WORKER**

Jan. 13 – March 15

COMMUNITY RESOURCE AND REFERRAL CTR

Las Vegas, NV

DEPARTMENT OF VETERAN AFFAIRS

Provide biopsychosocial assessment, diagnoses, education, brief counseling and referrals to homeless Veterans. Conduct outreach with community providers and attend annual Point in Time (PIT) Count. Collaborate with other members of the Health Care for Homeless Veterans team, Grant and Per Diem programs, Veterans Justice Outreach (VJO), Reentry and the VA Supportive Housing (VASH) programs. Refer to VA professional specialty clinics and community resources, as needed. Complete all necessary TMS trainings in a timely fashion. Agency Field Instructor for Clinical Social Work practicum students from the University of Nevada-Las Vegas.

**ADJUNCT FACULTY**

Jan. 13 - Present

SCHOOL OF SOCIAL WORK

Las Vegas, NV

UNIVERSITY OF NEVADA-LAS VEGAS

Teach advanced Research Methods to Social Work graduate students utilizing various methods of instruction. Evaluate student conceptual knowledge via exams, research papers and article reviews. Assist with exposure, application and mastery of the statistics utilizing the Statistical Package for the Social Sciences (SPSS).

**CLINICAL SOCIAL WORKER II**

March 05 – Jan. 13

S. NEVADA ADULT MENTAL HEALTH

Las Vegas, NV

STATE OF NEVADA

Completed biopsychosocial assessments, diagnosis, discharge planning and brief treatment interventions for consumers on a psychiatric observation unit and inpatient settings. Attended civil commitment court and collaborated with multidisciplinary treatment teams daily. Provided interim administrative and clinical coverage, as needed. Successfully supervised Clinical Social Work Interns to successful clinical licensure.

**LICENSED CLINICAL SOCIAL WORKER**

Jan. 03 – Jan. 09

PRISON HEALTH SERVICES

Las Vegas, NV

Conducted in custody competency evaluations at the City of Las Vegas Detention Center. Presented written reports to Municipal Court with competency findings and intervention recommendations. Licensed to conduct competency assessments in the State of Nevada.

**RONALD STRICKLAND**

**-Page 3-**

**CLINICAL SOCIAL WORKER III**

DEPT. OF CORRECTIONS

STATE OF NEVADA

Sept. 04 – March 05

Las Vegas, NV

Provided evidenced based psycho educational groups for a female prison population that included anger management, addictions and corrective thinking. Responsible for the formation and implementation of reentry procedures for women being released from prison. Supervised social work interns and one clinical social worker.

**LICENSED CLINICAL SOCIAL WORKER II**

STATE OF NEVADA

July 00 – Sept. 04

Las Vegas, NV

Acted as the primary liaison for newly created Mental Health Court between Adult Mental Health, District Court 16 and the Clark County Detention Center. Engaged in needs assessments, case management follow up and weekly court attendance providing treatment compliance updates. Functioned as a team leader providing clinical feedback and support in weekly meetings. Completed mental status exams, give DSM IV diagnoses and recommend treatment interventions. Performed competency evaluations to determine readiness for court.

**ADJUNCT FACULTY IN PSYCHOLOGY**

COMMUNITY COLLEGE OF S. NEVADA

Sept. 00 - Dec. 00

Las Vegas, NV

Presented materials for multiple learning styles. Prepared, administered and graded testing materials. Maintained flexible conference hours to accommodate student needs

**CASE MANAGEMENT SUPERVISOR**

OLIVE CREST FOSTER CARE

Sept. 99 - Sept. 00

Las Vegas, NV

Assessed, diagnosed and treated foster families/children. Developed and implemented a dual in-service training schedule for personnel and foster families. Assisted in the interview and selection process of applicants. Supervised case managers in all aspects of treatment. Initiated and performed child abuse assessments.

**RONALD STRICKLAND****-Page 4-****RESEARCH ASSISTANT II**

HARVARD MEDICAL SCHOOL

DEPARTMENT OF PSYCHIATRY

HARVARD FAMILIES AND ADDICTION PROGRAM

Oct. 97 - Aug. 99

Brockton, MA

Conducted structured clinical interviews covering substance abuse, relationship conflict and domestic violence to veterans. Coded, reviewed and prepared interview protocols for data entry. Assisted in evaluation and training of subsequent research assistants. Initiated and performed tasks related to subject recruitment in both inpatient and outpatient settings. Effectively communicated study objectives and longitudinal rationale to ensure continued collaboration of study participants. Directed site development by conducting chart reviews and obtaining patient demographic profiles.

**PROFESSIONAL LICENSE**

Licensed Clinical Social Worker (LCSW) in Nevada since 1999