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Feedback as a strategy for increasing the participation of consumers in the design, implementation, and evaluation of outpatient treatment programs for the chronic mentally disabled : a thesis ...

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FEEDBACK AS A STRATEGY FOR INCREASING THE PARTICIPATION OF CONSUMERS IN THE DESIGN, IMPLEMENTATION, AND EVALUATION OF OUTPATIENT TREATMENT PROGRAMS FOR THE CHRONIC MENTALLY DISABLED

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Abstract

Utilizing clients in decision-making, advocacy, and service delivery roles within the treatment environment is one means of providing the chronic mentally disabled with opportunities for participatory social roles, choice and control. However, client deficiencies of skill, experience, and motivation are suggested to be barriers to the successful accomplishment of this purpose. Strategies are needed to overcome these barriers. Feedback has been shown to be an effective, low-cost tool for increasing accomplishment in work settings.

The primary purpose of this study was to investigate the effectiveness of feedback in increasing the independent participation of a mental health consumer advisory group. This was investigated utilizing a multiple baseline design across the three behaviors required to fulfill the group's functions. A structured agenda, including all necessary tasks was also introduced for each of the three behaviors.

While inclusion of a task as an agenda item was found to be sufficient to assure a high level of participation, consistency of this high level was increased with feedback. As the study progressed, the percentage of consumer generated tasks on the agenda increased.

Results suggest that while this mental health consumer

group initially lacked the skills and knowledge to specify the tasks required to fulfill its functions when the tasks were specified, the group generally performed them with a high level of independent participation. This study also suggests that, with experience, skills and knowledge increased resulting in increased consumer group independence in specifying the tasks required to structure the agenda and fulfill its roles.

Feedback as a Strategy for Increasing the Participation of Consumers in the Design, Implementation, and Evaluation of Outpatient Treatment Programs for the Chronic Mentally Disabled

Approximately 1.5 million persons nationwide fall within the population of severely mentally disabled adults, individuals for whom 24 hr nursing care is inappropriate (NIMH CSP Guidelines, 1981). A strong movement in the last 10 years has been to normalize or integrate this group into society through community placement. Deinstitutionalization and community treatment have been an expression of assumptions that returning to community social structures and patterns of interpersonal relations would be helpful to patients. This movement is also an expression of cultural values about human conduct in our society. These values are that autonomy, competence, and independence are preferable to confinement, incompetence, and dependence (Estroff, 1981).

However, recent literature reflects disillusionment with community placement and the effort to integrate the mentally disabled into society. Although placed in the community, isolation and segregation from the non-patient

community, custodial care, stagnation, and dependency continue. Attitudes toward patients and treatment of patients by staff, families, each other, and the community have changed very little (Estroff, 1981).

Working against the continued stigma associated with mental illness and the continuing exclusion of the mentally disabled from society are a growing number of patient-controlled treatment, self-help, and advocacy programs (Estroff, 1981). These programs encourage former and current patients to be in charge of their own lives and treatment and are seen by some as part of a client-customer movement which would actively include psychiatric clients in the delivery and evaluation of mental health services (Morrison & Gaviria, 1979). This introduction will cover the potential benefits of client involvement in the mental health system, the potential problems in implementing programs featuring client participation, and the facilitation of effective client participation through the use of behavioral techniques.

Benefits

Efficacy of participatory social roles, choice and control. Current themes in psychosocial rehabilitation address the need to provide clients with opportunities for participatory social roles and choice and control

within the mental health treatment environment. Fairweather, Sanders, Cressler, and Maynard (1969) designed a community treatment program for the mentally disabled which emphasized these themes. Volunteers from a mental hospital open ward were randomly assigned to a lodge group or to a control group which continued treatment within the hospital. The lodge group lived in an old motel. Goals for the group included their becoming self-governing and running their own business. The members decided that their business would be a gardening and janitorial service. Upon moving to the lodge each person became part of a work team which included a leader responsible for its work, a worker, and a trainee. Community consultants handled medical problems and assisted in the development and maintenance of an accounting system and in improving janitorial work methods.

Initially, extensive supervision was provided by the project coordinator, an experienced psychologist. After the lodge society had been in existence for 8 mo he was replaced by a much less experienced graduate student. During this time an executive committee composed of the work-crew chiefs, cook, general manager, and business manager (all clients) regulated the social and work life of the lodge with increasing autonomy. At 16 mo the

project coordinator position was deleted. The executive committee became responsible for the development and operation of the lodge and paid non-professional staff became responsible for the supervision of the janitorial and gardening business.

The lodge was successful in enhancing the community adjustment of all members. Lodge members' time of living in the community and in community employment was significantly greater than that of control group members. At the conclusion of the 33 mo research project, during which the lodge society had become increasingly independent, the group was able to successfully move into a completely unsupervised community placement.

Fairweather's findings that chronic mental patients are able to meet expectations for socially appropriate behavior, autonomy, participation, and work performance have been supported by others. Lamb and Goertzel (1972) compared the effectiveness of high and low expectation programs in keeping long-term patients out of the hospital and in increasing their level of vocational and social functioning. The high-expectation settings included a half-way house, a day treatment center, and a sheltered workshop. Low-expectation board and care homes served as a comparison group. The high-expectation group did

function at a significantly higher vocational and social level while in the community. At 24 mo, 50% of the demonstration group was involved in structured activities 90% of the time. Structured activities included a workshop, work placement, paid employment, and being a housewife. Only 19% of the comparison group was involved in structured activities at 24 mo. Socialization scale ratings also indicated greater adjustment for the high-expectation group over time, while the low-expectation group remained unchanged. However, contrary to expectations, they found that a high-expectation environment increased the rate of hospitalization and did not increase time spent in the community.

In partial contrast to the results of the above study, Stein and Test (1978), in a community treatment approach which focused on teaching of coping skills, decreased client hospitalization and increased client vocational and social functioning. On arrival at a state hospital, a random sample of patients were assigned to the Training in Community Living program. Treatment consisted of participation in a full schedule of daily living activities with pharmacotherapy utilized where appropriate. On-the-spot staff taught and assisted patients with all activities of daily living. They also assisted with vocational

placement, constructive use of leisure time and development of effective social skills. Intensive staff contact with patients was emphasized initially and gradually faded as the patients progressed. Even after there was little staff contact, staff remained aware of the clients' functioning and intervened assertively at the first sign of trouble.

In a 12 mo period, clients in the Training in Community Living program spent significantly less time in psychiatric facilities and significantly more time in unsupervised, independent community living facilities than the control group. They also spent significantly more time in sheltered and full-time competitive employment situations. On some measures the social adjustment of program participants was significantly enhanced. Additionally, patients' subjective satisfaction with life was at a significantly higher level than that of the control group.

Cerniglia, Horenstein, and Christensen (1978) describe a study which provided some support for the positive effects of increasing patient decision-making on behavioral adjustment. Self-government groups were established within group homes. Three intervention conditions existed. In Experimental Group I, self-

government groups met every 2 weeks for 1½ to 2 hr. Each was staff led and designed to assist residents in identifying, making, and implementing decisions related to their daily lives and the operation of the homes (menu planning, work assignments, trip planning, etc.). Between meetings the clients were assisted in implementing their decisions. In Experimental Group II, a group discussion was held every 2 weeks covering the same topics. However, no decisions were made by the group. Changes paralleling those made in the homes with Experimental Group I were implemented by staff. The control group received no intervention.

No significant changes were shown in Tennessee Self Concept Scale or Rotter Locus of Control scores for either of the experimental groups. However, behavioral adjustment of Group I as measured by Hospital Adjustment Scores was significantly increased by the intervention.

These studies suggest that treatment environments providing opportunities for participatory social roles, choice, and control to the chronic mentally disabled have potential for increasing their community integration and their overall adjustment. Other programs have employed clients in various decision-making, client advocacy, service, and delivery roles. While clients'

participation in these programs has been noted to have beneficial effects, specific measures of client benefits have been lacking. Nevertheless, a brief description of programs utilizing varying degrees of client control and involvement as an integral part of treatment will illustrate the forms mental health client consumerism may take.

Program descriptions. The Mental Patients Association of Vancouver, British Columbia, an organization of ex-patients, operates a drop-in center as well as five cooperative residents. All decisions are made by the members at weekly business meetings using the democratic process. The Association has been in existence since 1971 and has been awarded a grant for local projects by the Canadian Government (Kopolow, 1981).

Project Release, an ex-patient organization, is now defunct because of lack of funding. However, during its existence it concentrated on exposing problems of inadequate housing and hospital care and established a community center. Interestingly, there were no distinctions in membership between staff and clients. Each member was required to serve on one or more of the committees necessary to keep the project going. (Kopolow, 1981).

Darley (1974) reported on restructuring a day center by establishing a therapeutic community in which all decisions (other than administrative details required by the city health department) were made by patients and staff together. The purpose of the restructuring was to combat the institutionalization and guilt of the clients, to show clients that negative emotions are a healthy, normal, if unpleasant reality, and to convince clients that they were capable of competence and independence. An important feature of this project was recognition that mistakes, even serious ones, would be made and that clients needed to be able to make those mistakes to learn.

Kopolow (1981) described two programs resulting from collaborative efforts between patient associations and mental health centers. One was a small drop-in center and hot-line run by the Mental Patients Rights Association in Lake Worth, Florida and funded by the South County Community Mental Health Center of Loxahatchee, Florida. The other was the San Fernando Valley Community Mental Health Center, Van Nuys, CA. This center used ex-patient and other volunteers to establish a number of self-help and friendship groups.

In addition to benefits to clients from participation, programs may also improve by becoming more responsive to

clients' needs. Clients are an important source of information regarding client satisfaction and concerns (Morrison & Gaviria, 1979). Because of their unique position, involvement of clients not only as respondents but also as designers and administrators of client satisfaction surveys could improve the validity of the measures (Windle & Paschall, 1981).

Morrison and Cometa (1979) described in detail the formation of a client advisory board for a community mental health clinic. The purposes of the board were threefold: (a) to assist staff in the development and/or evaluation of mental health services, (b) to evaluate and make changes in the physical setting of the clinic, and (c) to evaluate and make recommendations for appropriate changes in the role of staff and students as well as clinic procedures. Three elected members served for 3 mo terms on the board. Any other client was welcome to attend meetings. Staff also attended meetings. Examples of board transactions illustrate the broad scope of it's involvement. It evaluated 10 clinic programs including the group psychotherapy and assertiveness training programs, it sponsored two seminars presenting clients with different points of view on electroshock-therapy, and it evaluated the characteristics

of the client waiting room.

There were 72 recommendations for changes in program proposed by the client advisory council during the 12 mo of the study, of which 82% were implemented. Of 28 recommendations for changes in the physical environment of the clinic, 89% were implemented. All of the nine recommended changes in procedures and personnel were made. While it's benefit to participating clients and to the mental health clinic program is undocumented, the strength of this council's impact upon the mental health clinic is well established.

Problems

Client consumerism offers the mentally disabled an opportunity to fulfill a valid social role. However, if these benefits are to be achieved, client consumer efforts must be successful. Although having the capacity for accomplishment and contribution, the barriers to achievement for the mentally disabled are considerable. Many problems are directly related to the problems inherent in chronic mental illness. Those who have been labeled chronically mentally disabled have been described as:

> ...extremely dependent persons, deficient in daily living and coping skills, vulnerable to stress, experiencing difficulty in achieving

> close or symmetrical relations with others, and often unable to provide for their own subsistence, responding to problems in any of these areas by becoming symptomatic or psychotic. (Estroff, 1981, p. 119)

Caro (1981) points to the practical difficulties inherent in the development of extensive and effective consumer participation when the targeted consumer participants are preoccupied with basic survival problems. In his study of variations in the amount of choice and control available to aged sheltered care residents, Moos (1981a) found that residents with more living and coping skills were more likely to live in facilities with high choice and were better able to take advantage of environmental opportunities. Conversely, those with fewer personal resources lived in settings with less choice available, were less able to respond to environmental variations, and were more constrained by environmental demands. Moos' study suggests that people who are functioning poorly may find the increased demands of participation stressful. As those labelled mentally ill are described as deficient in living and coping skills and vulnerable to stress, this problem may indeed be a barrier to broad participation of mental health system

clients in the development and evaluation of services.

Lack of leadership skills may also be a problem in the development of client consumerism in mental health programs. Leadership is developed in a learning process in which capacities and skills gained at one level prepare the leader for new and larger tasks at the next level. Briscoe, Hoffman, and Bailey (1975) in their work with a Headstart policy-board composed of consumers of service, point out that lack of leadership experience and skill is typical of policy-boards composed of consumers. They suggest that this lack of skill is a real deterrent to effective participation by consumers. Morrison and Cometa (1979) recognize that much of the success of their client advisory board was due to the majority of the board members being non-psychotic, well-educated persons with adequate verbal and social skills.

Darley (1974) also points to the importance of recognizing that skills of self-governance develop with experience. He says that in learning to be self-governing, clients of the mental health day program he described made many mistakes and learned from those mistakes. Darley suggests that many client governed programs fail because they do not have the resources to keep going while the

clients are learning to lead and manage the program.

These problems of client deficiency of skills, experience, and motivation are directly related to the goals and potential benefits of client participation in mental health program governance. From this perspective, successful client consumer participation in the planning, evaluation, and delivery of mental health services may be seen as a method of treatment. It should follow that it is the responsibility of mental health professionals, behavioral psychologists in particular, to investigate the effectiveness of this participation in developing people's ability to function more fully in society. This responsibility would also lead to the exploration of methods which would support the development of successful participation.

Behavioral Interventions

Reinforcing participation. Behavioral interventions have targeted client behaviors related to the successful performance of client consumer groups. Miller and Miller (1970) suggest that participation in self-help groups must be reinforced if it is to be maintained. The long range social benefits of participation were not sufficiently strong reinforcers to maintain the participation of welfare clients in a self-help group.

However, with the provision of more immediate reinforcement such as toys, stoves, furniture, clothes, assistance with housing, police, and finding jobs, high attendance rates were maintained. Similarly, pre-delinquents at Achievement House (Fixen, Phillips, & Wolf, 1973) were successfully motivated to participate in a self-government system by a point system as well as by an increase in responsibility for setting the consequences of rule violation.

Finally, simply attending to and accepting the recommendations a client board offers may serve to reinforce participation. Examining Morrison and Cometa's report on an advisory board, it is possible that the high rate of recommendations the board made during the 12 mo period of the study (109 recommendations) was due to the reinforcing value of having a high proportion of recommendations implemented. In fact, O'Brien, Azrin, & Henson (1969) documented the effect of granting requests in increasing the number of suggested improvements in treatment offered in a group of chronic schizophrenics.

Skill training. In addition to reinforcing participation, other studies have attempted to directly train participants' skills to improve the quality of performance. Fairweather, et al. (1969) utilized information feedback to improve the adequacy of problem

solutions of the lodge society's executive committee by conducting a weekly evaluation of the adequacy of the committee's problem solutions. While clinical observation suggested that this intervention was successful, it's efficacy was unsupported by systematically collected data.

In analyzing the difficulties of a policy-board composed of nine lower socio-economic adults, Briscoe, Hoffman, & Bailey (1975) found one cause of ineffectiveness to be lack of familiarity with formal group decision-making procedures. They attempted to correct this deficiency by training group members in problem solving skills. Their method presented tasks graduated from simple to difficult and employed fading, shaping, prompting, and differential social reinforcement of correct problem solving responses. The training was effective in training problem solving skills but the skills were not maintained at high levels in all subjects. Additionally, no information was available on whether the board successfully accomplished more of its objectives as a result of the training. Therefore, the relevance of the training is in question.

Feedback. Attempting to increase the successful functioning of mentally disabled clients in governing roles is analogous to the goals of increasing

accomplishment and productivity in work settings. It may be that some of the methods employed in business settings are also relevant for improving the productivity of client consumer groups in mental health settings. In particular, organization behavior management literature shows feedback alone or in combination with other procedures to be an effective, low-cost tool for improving performance of behaviors as diverse as goal writing (Ford, 1980), friendliness of fast food restaurant staff (Komaki, Blood, & Holder, 1980), safe performance of tasks (Komaki, Heinbrann, & Lawson, 1980), delivery of training sessions (Panyan, Boozer, & Morris, 1970), staff suggestions (Quilitch, 1978), and the completion of production tasks (Emmet, 1978).

A feedback system involves the systematic collection of performance information and the systematic delivery of this information to individuals to give direction to performance and confirmation of desired performance (Gilbert, 1978; Krumhaus & Malott, 1980; Prue, Krapfl, Noah, Cannon, & Maley, 1980). Feedback programs are often relatively low-cost and cost-effective which allows their use in organizations with limited resources (Ford, 1980). Additionally, feedback on the outcome produced by the cooperative behaviors of many people can be used

to improve and maintain improvement of those behaviors (Runnion, Johnson, & McWhorter, 1978).

Both of these advantages are illustrated in the use of informational feedback to reduce truck turnaround time in materials transportation (Runnion, Johnson, & McWhorter, 1978). Turnaround time encompassed the cooperative behaviors required from the driver, warehouse employees, and other plant personnel. Data were recorded mechanically in each truck and reported to each plant manager. Public and private social reinforcers were presented on a variable interval schedule to both individual workers and groups of workers contingent on meeting performance goals during all conditions. Drivers also received instructions on how to decrease turnaround time during all conditions. Truck turnaround time was reduced from an average of 67 min to an average of 37 min resulting in an increase in internal transportation of approximately 12% more materials. An average of 25 hr per week was required to analyze and calculate data. Reportedly, the cost of staff time was more than offset by the increased efficiency of the transportation fleet.

Thus, because it is low-cost and effective, feedback has become a widely used strategy for improving worker performance in business settings (Prue & Fairbank, 1981).

However, despite Fairweather's success in using feedback to improve the performance of task-oriented groups comprised of chronic mentally disabled individuals, and despite the informal use of feedback in clinical settings, its efficacy as a treatment strategy with the mentally disabled population has not been widely tested.

The primary purpose of the present study was to investigate the effectiveness of feedback in increasing the independent participation of consumers in the design and implementation of an outpatient treatment program for the chronically mentally disabled. A secondary purpose was to further document the benefits of client-consumerism for programs for the mentally disabled.

Method

Participants

The client-participants of this study were members of the Member Advisory Council (MAC) of the Socialization Center. Five Council members were elected from the general membership of the Center to a 6 mo. term of office. Elected members unable to complete their term of office were replaced by a majority vote of the Council. This occurred five times. The purpose of the MAC is to increase the overall client enjoyment of the Center by providing activities, by facilitating communication between the

membership and staff, and by participating in program planning.

Setting

The setting for this study was the Community Re-Entry Project Socialization Center, a drop-in program for people with chronic mental disabilities. During this study an average of approximately 45 people per day visited the Center with slightly less than 200 different people served per month.

The Socialization Center is a state funded, community based program operated by the University of the Pacific Psychology Department. Staff consists of a program director, graduate and undergraduate student staff and client aides.

Design and Measurement

Treatment was applied sequentially to three target behaviors in a multiple baseline design. Target behaviors included the three areas of MAC functioning: (a) providing activities for the benefit of the Socialization Center membership (activities), (b) facilitating communication between the membership and staff of the Socialization Center (communication), and (c) program planning for the Socialization Center (planning).

Activities. Providing activities for the benefit of the Socialization Center membership included MAC

participation in the implementation of any program plan whether a one-time activity such as providing a planter box for the front of the Center or an on-going activity such as a monthly potluck. During this study, MAC activities consisted of a monthly dance or bingo night and a monthly potluck. A task analysis was completed for each activity (Appendix A). A complete agenda for each meeting included the items from the task analysis which needed to be considered that week.

Two primary outcome measures were utilized. The first was the percentage of items required for each week which were actually included on the agenda by the Council members. For example, two meetings before each dance a theme had to be decided and eight responsibilities such as clean up, publicity, etc., assigned. All nine of these items should be on the agenda. An agenda on which Council members included six of the nine necessary items was 67% complete. Data were summarized as the mean number of items per meeting and the percentage of MAC generated items, for each phase of the study for each target behavior.

The second measure assessed the level of MAC participation along two dimensions using two sub-scales, the Task Work Rating Sub-Scale (TWRS) and the Task Self-Direction Rating Sub-Scale (TSDRS) (Appendix D). The

TWRS and the TSDRS were developed during the previous MAC and pretested for ease of use and inter-observer agreement during the activities sponsored by that Council.

The TWRS rated the percentage of work on a task that was done by the Council on a seven point scale ranging from 0% to 100%. To illustrate, if the Council completed all, 100%, of the work on a task they were rated at the Level 6. If the Council did none, 0%, of the work on a task they received a 0 rating. If the Council did about half the work on a task, 40%-59%, they received a rating of 3.

The Task Self-Direction Rating Scale (TSDRS) rated the level of MAC independence on working on the specified task on a 7 point scale. A 7 rating on the TSDRS refers to instances in which the MAC worked on the task with no staff prompts or direction. A low score means less independence was demonstrated.

A TWRS and a TSDRS were completed by a supervising staff person for each task to be worked on outside of the meeting (e.g., dance publicity and Center clean up) and rated the work on that task of the Council as a whole. Similarly, a TWRS and TSDRS were completed by the staff liaison for each agenda item worked on within the meeting. The author of the study was the staff liaison for the

course of the study.

Prior to being a rater, each staff received training in the use of the scales. Training consisted of instructions to increase staff consistency in assisting the Council and instructions and practice in using the rating scales.

Data were summarized for tasks worked on within the meetings by summing the weekly means of the TWRS and the TSDRS scores. A few tasks were worked on outside the weekly meetings. Therefore, data were summarized for these tasks by first summing the weekly means of the TWRS and the TSDRS and then computing the mean for each phase of the study for each behavior.

Thirty reliability probes were taken individually on tasks such as shopping, setup, cleanup, and cooking worked on during the 10 MAC sponsored activities. Inter-observer agreement was computed using the Pearson product-moment correlation coefficient. A correlation of .78 was obtained.

Communication. Facilitating communication between the membership and staff of the Socialization Center included all activities designed to solicit information from the membership. During this study communication consisted of interviews with Center members which were compiled in a monthly State of the Center Report and

submitted to the Director of the Socialization Center.

A task analysis of all the items required for the completion of the State of the Center Report is included in Appendix B. A complete MAC agenda included those items required each week for completion of the report. As for the Activities variable, the first outcome measure was the percentage of necessary weekly items relating to the State of the Center Report actually placed on the agenda by the Council members, for each meeting. To illustrate, 3 weeks before submitting the State of the Center Report to the Center director, the MAC should list possible interview questions, select questions, and write out and submit the selected questions to the director for approval. All three of these items should be included on the agenda. An agenda generated by the Council members which included only one of these items would be 33% complete. As with Activities, data were summarized as the mean number of items per meeting and the percentage of MAC generated items, for each phase of the study for each target behavior.

The second outcome measure was the level of Council participation on the tasks related to the State of the Center Report. Council participation for each task to be worked on outside of the meeting (e.g., interviewing the general membership) again was assessed by a Task Work

Rating Sub-Scale and a Task Self-Direction Rating Sub-Scale completed by the supervising staff person. Similarly, the staff liaison also completed a TWRS and a TSDRS for each agenda item requiring a decision within the meeting. The weekly mean of all participating ratings indicate the level of Council task participation. Data were summarized as reported.

For tasks worked on within the meetings the weekly means of the TWRS and the TSDRS scores were summed. A few tasks were worked on outside the weekly meetings. Therefore, data were summarized for these tasks by first summing the weekly means of the TWRS and the TSDRS and then computing the mean for each phase of the study for each behavior.

Planning. Council program planning for the Socialization Center included the development of program objectives and/or the identification of the means for reaching these objectives in any area of Center concern specified in memos to the Council from the Center director. These recommendations were formally submitted to the program director for his consideration. Also included were any subsequent actions taken to follow through on the director's response.

Agenda items required for Planning are specified in

the task analysis for planning, Appendix C. Outcome measures again included the percentage of necessary weekly items related to planning placed on the agenda and the level of Council task participation. Data were summarized and reported as for Activities and Communication.

Additional secondary outcome variables included Council accomplishment, member perceptions of the Member Advisory Council, and the impact of the Council on the Socialization Center program. Accomplishment measures included a tally of the number of Council sponsored activities, the number of ideas stemming from the general membership included in the State of the Center Report, and the number of planning projects or proposals submitted in Council Advisory Actions. Planning projects or proposals were identified as completed, in progress, or not completed thereby indicating MAC impact on the Socialization Center.

To describe the Council members' perception of the Council the Moos Group Environment Scale (GES) (1981b) was administered at the completion of the study (approximately 5 mo after the Council was elected). Ten subscales comprise the GES which measures the social-environmental characteristics of task-oriented, social, and psychotherapy and mutual support groups. The subscales assess three dimensions. Relationship dimensions are

measured by Cohesion, Leader Support, and Expressiveness subscales. Personal Growth dimensions are measured by the Independence, Task Orientation, Self-Discovery, and Anger and Aggression subscales. System Maintenance and System Change dimensions are measured by the Order and Organization, Leader Control, and Innovation subscales. The mean and standard deviation of Socialization Center Member Advisory Council scores on these dimensions were compared to norms based on the non-mental health client task oriented groups.

To provide some measure of the overall cost of the Member Advisory Council to the Socialization Center and the specific cost of the structure and feedback procedure used in this study, staff liaison time spent with the MAC was measured. Measures included the total liaison time spent in agenda setting, problem solving, and the business meeting. Feedback time during the business meeting was also measured. The weekly mean staff liaison time spent with the Council in these activities was calculated.

Procedure

Baseline. Baseline conditions were initiated by a memo to the Council from the Socialization Center director requesting that the Council fulfill its three functions by continuing to sponsor activities, by communicating the ideas of the general membership to the staff in a monthly

State of the Center Report, and by submitting monthly program planning recommendations to the director. The memo invited the ideas of the general membership and recommendations of the Council in specific current areas of concern. It specified dates for upcoming Council sponsored activities and dates for submission of the State of the Center Report and planning recommendations.

Conditions during baseline included weekly agenda setting meetings between the Council chairperson, other interested MAC members, and the staff liaison to the Council. During the initial meeting a written analysis of all the tasks required for the performance of the Council's functions was briefly explained to the chairperson. This analysis was available to the chairperson during each agenda setting meeting as well as during the Council meetings. During baseline the liaison did not add any items to the agenda which were not included by the Council members.

The staff liaison attended each Council meeting and provided information as required regarding Center procedures (e.g., how to obtain the money allocated for the potluck). The liaison also provided direction, prompts, and assistance to the Council both within the meetings and in working on tasks outside the meetings as necessary.

Undergraduate staff supervising tasks worked on outside the meetings also provided direction, prompts, and assistance as needed. This assistance was provided due to the skill deficiencies and vulnerability to stress of the Council members. The level of staff assistance required during baseline and treatment is reflected in the TSDRS and TWRS ratings.

Structure. During structure, the liaison, without comment or explanation, added to the agenda during the agenda setting session any items from the task analysis necessary for the accomplishment of existing activities which were not included by the MAC. Structure was initiated for Activities during the first 5 weeks of the study resulting in no baseline being taken during Activities. This was seen as necessary because of the skill deficiencies and vulnerability to stress of the individual members of the MAC. During Week 5 structure was introduced for the target behavior Planning. During structure the staff liaison and undergraduate staff continued to provide direction, prompts, and assistance as required to the Council both within the meetings and in working on tasks outside the meetings.

Feedback. Systematic feedback was introduced through a weekly review of all Council tasks listed on

the previous week's agenda. There was no mention of which Council members worked on which tasks. These included those tasks worked on outside the meeting and items addressed within the meeting. Feedback occurred at the beginning of each Council meeting and consisted of discussing the Participation Ratings for each task. The mean level of participation for all tasks for the week was computed and graphed for display during the feedback session. Evaluation, feedback, computation, and graphing took approximately 5 min of meeting time. During the intervention, the staff liaison and undergraduate staff continued to provide direction, prompts, and assistance to the Council both within the meetings and in working on tasks outside the meetings.

Following 5 weeks structure, feedback was applied to the target behavior Activities. Following 4 weeks of baseline and 7 weeks of structure, feedback was applied to Communication. Following 10 weeks of baseline and 8 weeks of structure, feedback was applied to planning.

Results

Agenda Items

During baseline conditions few MAC generated agenda items appeared. With the addition of structure, MAC generated items were at a low level for all behaviors. When feedback

was added to structure the mean percent of Council generated items increased slightly from 68% to 75% for Activities. The mean increased moderately for Communication and Planning with increases from 29% to 43% and from 21% to 50% respectively. (See Figure 1 and Table 1.)

A visual examination of the data reveals that during weeks 12, 13, 14, 15, and 16 lower levels of MAC generated agenda items occurred. During this period the Council chairperson was experiencing personal difficulties. His MAC participation had decreased and he was having interpersonal problems with other Council members. This period ended with his resignation and replacement by a person who had served as chairperson of a previous Council.

There was a great deal of variability in the number of agenda items per meeting. This can be partially explained by a variability in the actual workload. The variability is also due to the staff liaison's decisions to introduce a bare minimum of agenda items during weeks of high stress when the chairperson's difficulties were affecting overall Council performance. Another source of variability in the actual number of agenda items may be explained by MAC decisions to drop Activity related task analysis items from the agenda that they did not feel were essential.

Table 1

Summary of MAC Agenda Items (Tasks)

	Activities	Communication	Planning
Baseline:			
Mean # Items Across Meetings	Baseline not taken	0	.37
% MAC Generated Items	Baseline not taken	--	100%
# Meetings	0	4	9
Structure:			
Mean # Items Across Meetings	8.33	2	2
% MAC Generated Items	68%	29%	21%
# Meetings	5	6	7
Structure & Feedback:			
Mean # Items Across Meetings	4.6	1.55	4.67
% MAC Generated Items	75%	43%	50%
# Meetings	14	9	3

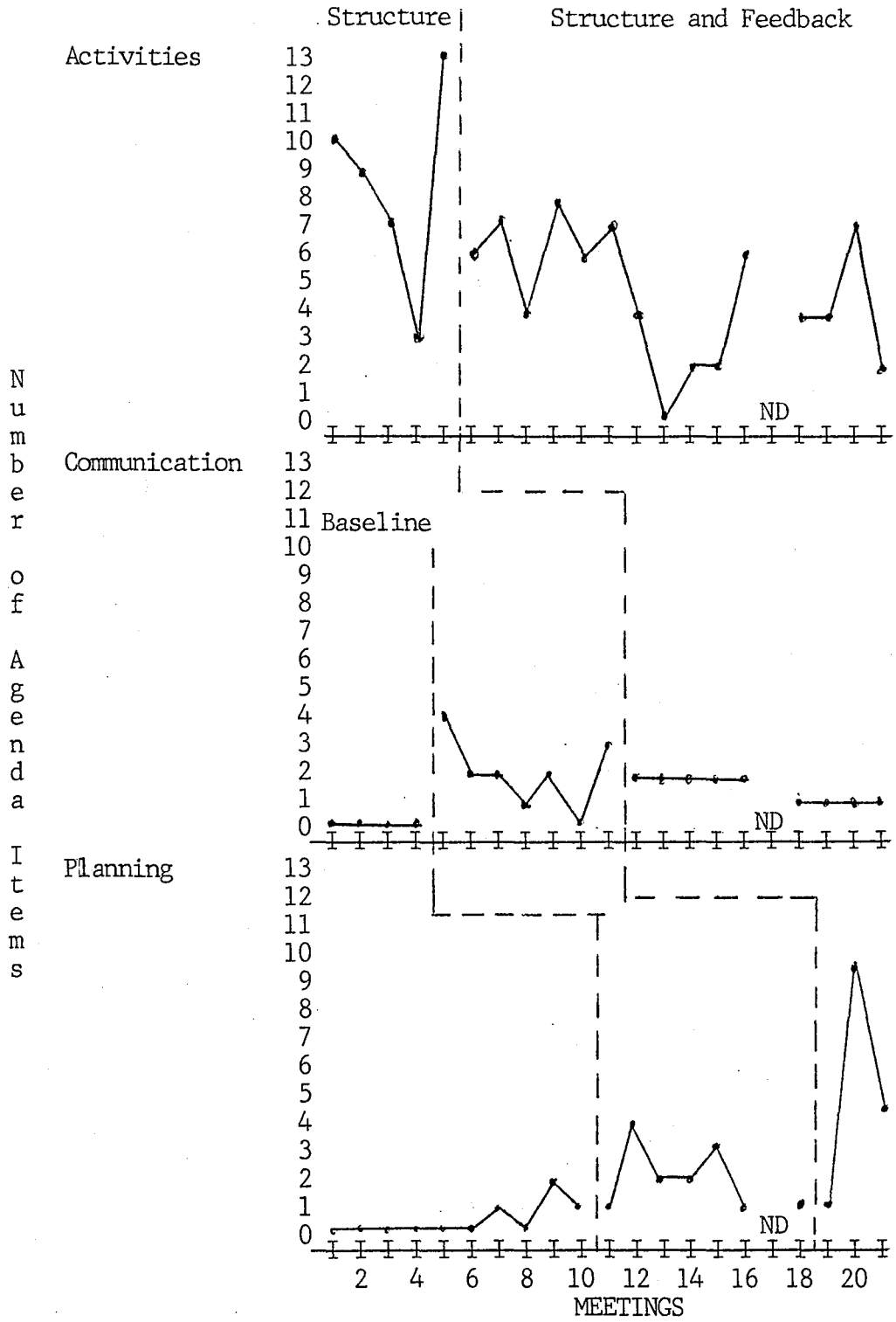
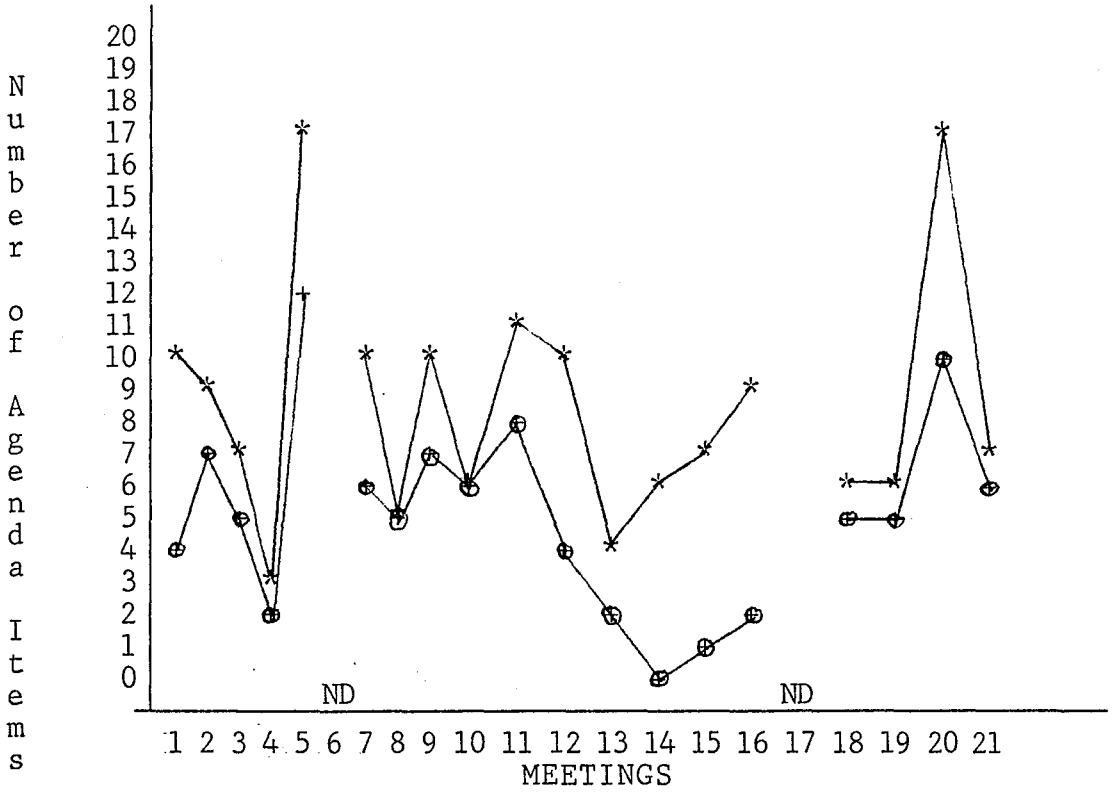


Figure 1 Number of agenda items (tasks) per meeting ND=no data for that meeting



* = Total Agenda Items
⊕ = MAC Generated Agenda Items
ND= No Data

Figure 2 Total Agenda Items/MAC Generated Agenda Items

Participation Level

With structure, the participation level for tasks addressed within the meeting for all three behaviors was at a consistently high level as shown in Table 2 and Figure 2. The mean sum of the TWRS and the TSDRS for each meeting was 11.48 for Activities, 11.62 for Communication, and 11.47 for Planning out of a possible score of 12. The addition of feedback did not substantially affect the mean participation levels with Activities at 11.47, Communication at 11.61 and Planning at 11.97. Visually examining the data, lowered participation levels for Communication and Planning for weeks 13, 14, 15, and 16 correspond with the period of difficulty and replacement of the MAC chairperson described earlier.

Participation levels on tasks worked on outside the meetings, presented in Table 3, were consistently lower than the levels for tasks worked on inside the meetings. During baseline there were no tasks outside the meeting for Communication and only one task for Planning which was completed at a very low level of participation (6).

Combining the TWRS and the TSDRS during structure, the mean participation level per week in which there were tasks outside the meeting was at 10.85 for Activities, 11.55 for Communication, and 7.42 for Planning. With the addition of

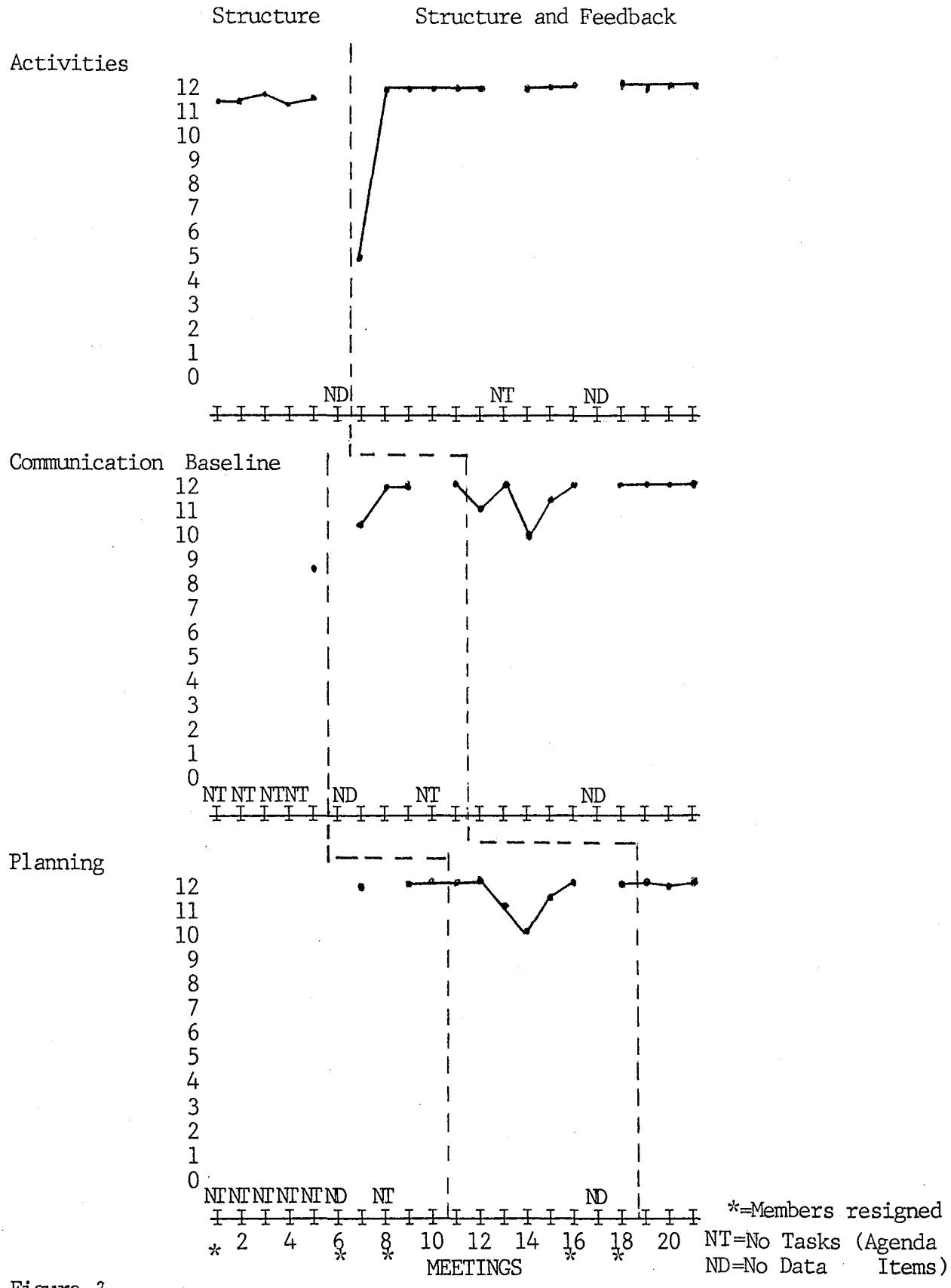


Figure 3

MAC Participation Levels on Agenda Items (Tasks) Inside Meetings

Table 2

Summary of MAC Participation Level on Tasks Within Meeting (TSDRS and TWRS Combined)

	Activities	Communication	Planning
Baseline:			
Mean	Baseline not taken		12
Range	Baseline not taken		
Mean # Agenda Items	Baseline not taken	0	.45
Structure:			
Mean	11.48	11.62	11.47
Range	11.3-11.7	10-12	10-12
Mean # Agenda Items	8.33	2	2
Structure & Feedback:			
Mean	11.47	11.61	11.97
Range	5.1-12	12	11.9-12
Mean # Agenda Items	4.6	1.55	4.67

Table 3

Summary of MAC Participation Level on Tasks Outside Meetings (TSDRS & TWRS Combined)

	Activities	Communication	Planning
Baseline:			
Weekly Mean Participation Level	Baseline not taken	No tasks	6
Range	b.n.t.	No tasks	6
# Weeks with Tasks		0	1
Structure:			
Weekly Mean Participation Level	10.85	11.55	7.425
Range	10.25-11.8	11.3-11.8	0-10.7
# Weeks with Tasks	3	2	4
Structure & Feedback:			
Weekly Mean Participation Level	11.63	11	10.5
Range	10.8-12	11	10.5
# Weeks with Tasks	6	1	1

feedback the participation level increased for Activities to 11.63 and Planning to 10.5. The level for Communication remained about the same.

These means are based on a total of only 18 scores. Combined across all behaviors for each phase of the study the mean level of participation was 6 for baseline, 9.52 for structure, and 11.41 for structure plus feedback.

Secondary Outcome Measures

The accomplishment of the participant MAC is compared to that of a cohort group, the previous MAC in Table 4. The data show no change in the number of MAC sponsored Activities. Communication during the previous Council was at a zero level. During the participant MAC, three State of the Center Reports were completed and submitted to the director. These reports included a total of 15 questions and 48 interviews. Four planning projects and proposals were initiated for both groups. Both groups had completed one project or proposal with the cohort group not completing a third and the participant group having two projects in progress and one not completed at the completion of the study.

Summarizing the results of the administration of the Moos Group Environmentsl Scale (GES) (1981b), MAC means for most subscales were similar to the normed task oriented groups means as pictured in Table 5. The normed task

Table 4

Summary of MAC Accomplishment

	Previous MAC (4 Months Data Collected)	Participant MAC (5 Months Data Collected) Includes Baseline and Treatment
Activities	4 evening activities 4 luncheon activities	6 evening activities 4 luncheon activities
Communication	None - Discussed Survey but dropped	State of Center Reports Over 3 month period 3 reports submitted included 15 questions and 48 members interviewed
Planning Projects or Proposals	Completed - 1 Not completed - 3	Completed - 1 In progress, may be completed - 2 Not completed - 1

Table 5

Moos Group Environment Scale (GES) Subscale Means and Standard Deviations for MAC and Normed Task-oriented Groups

	MAC Group		Non-Mental Health Client Normed Task-Oriented (N=39) Groups	
Subscales	Mean	SD	Mean	SD
Cohesion	5.2	2.59	6.02	1.60
Leader Support	6.2	2.77	6.01	1.72
Expressiveness	4.2	1.92	5.40	1.43
Independence	4.6	1.67	6.58	1.50
Task Orientation	5.6	1.34	5.99	1.36
Self-Discovery	4.2	2.17	4.25	1.63
Anger & Aggression	4.0	3.54	4.33	1.60
Order & Organization	5.8	2.68	5.38	1.61
Leader Control	4.6	1.81	5.11	1.82
Innovation	5.2	.84	5.15	1.40

oriented groups highest four scores were in Cohesion, Leader Support, Independence, and Task-Orientation. The MAC scored highest in Leader Support, Task Orientation, and Order and Organization with Cohesion and Innovation tying for fourth position.

The lowest scores for the normed task oriented group were in Self-Discovery and Anger and Aggression. The lowest score for the MAC was in Anger and Aggression with Self-Discovery and Expressiveness tying for second lowest.

Data collected over an 11 week period during the study showed the staff liaison spending a mean of 1.73 hours per week on MAC business including agenda setting, the weekly meeting and problem solving. Approximately 5 min per weekly MAC meeting was spent giving feedback.

Discussion

The primary purpose of the present study was to investigate the effectiveness of feedback in increasing the independent participation of the Socialization Center Member Advisory Council in fulfilling the Council's three functions, Activities, Communication, and Planning. While within the meetings, inclusion of an item on the agenda was enough to assure a high participation level without the application of feedback. More consistency was found with feedback.

Tasks worked on outside the meetings showed an increase in participation levels with the addition of feedback for two out of three behaviors. This finding however was based on a relatively small number of data points. An uncontrollable variable, the difficulties of the Council chairperson, also affected data.

The most notable finding of this study was that inclusion of an agenda item was sufficient to insure a high level of independent work and self-direction on that item within the MAC meeting and a relatively high participation on items worked on by members as a group outside the meeting. However, a lack of the necessary knowledge and skills to independently specify these agenda items is indicated by generally low levels of MAC generated agenda items throughout the study. With staff input to complete each agenda the MAC had the opportunity to perform its functions. As the study progressed the level of MAC generated agenda items increased reflecting decreased staff involvement as MAC knowledge and skills increased.

The findings of this study support those of Fairweather (1969) that the chronic mentally ill may be able as a group to be productive and follow through on enterprises to an extent that as individuals they are not able. This is suggested by the higher participation levels for tasks that

were typically done by the group (tasks worked on within the meetings) than those for tasks typically done by individuals alone (many tasks worked on outside the meetings).

Throughout the course of the study the functioning of individuals within the MAC varied. Typically Council members were aware of each others "down time" and compensated for each other. Four individuals in addition to the chairperson resigned for reasons related to personal difficulties. Only when the chairperson was having difficulties was the overall functioning of the Council affected. Even in this situation the decrease in TWRS and TSDRS levels did not go below 5. For the TWRS this indicates that the MAC did between 80% and 99% of the work on a task. For the TSDRS level 5 indicates that one prompt to work on the task and/or very minimal staff direction on how to do the task was needed.

Examining the comparison of the accomplishments of the current MAC and the prior MAC, slightly more was accomplished by the current MAC. Given the high participation levels of the MAC, what was accomplished was done more independently.

The major problem which interferred with the development of independent participation by the MAC was the difficulty and resignation of the chairperson. This problem might be prevented in the future by having two co-chairpersons sharing

the responsibility of this position.

Another problem was the restlessness and inattentiveness of Council members whenever meetings went over ½ hour. To solve this problem and to simplify the role of the group and decrease stress, it might be helpful to have an Activities Advisory Group and a Communication and Planning Advisory Group.

To conclude, the present study suggests that a mental health consumer group lacks the skills and knowledge to specify the tasks needed to fulfill its functions. However, when these tasks are specified the group generally performs them with a high level of independent work and self-direction, perceiving their functioning similarly to the perception of other non-mental health client task oriented groups. Further, it suggests that the group is capable of increasing its skill and knowledge resulting in increased independence in specifying required tasks. The studied group affected the general program slightly more than the untreated cohort group.

References

Briscoe, R. V., Hoffman, D. B., & Bailey, J. S. (1975). Behavioral community psychology: Training a community board to problem solve. Journal of Applied Behavior Analysis, 8, 157-168.

Caro, F. G. (1981). Reaction of a skeptical sociologist. Community Mental Health Journal, 17, 77-82.

Cerniglia, R. P., Horenstein, D., & Christensen, E. W. (1978). Group decision-making and self-management in the treatment of psychiatric patients. Journal of Clinical Psychology, 34, 489-493.

Darley, P. J. (1974). Who shall hold the conch? Some thoughts on community control of mental health programs. Community Mental Health Journal, 10, 185-191.

Emmet, G. D. (1978). Measuring the impact of group performance feedback versus individual performance feedback in an industrial setting. Journal of Organizational Behavior Management, 1, 134-141.

Estroff, S. E. (1981). Psychiatric deinstitutionalization: A sociocultural analysis. Journal of Social Issues, 37, 116-132.

Fairweather, G. W., Sanders, D. H., Cressler, D. L., & Maynard, H. (1969). Community life for the mentally ill. Chicago: Aldine Press

Fixen, D. L., Phillips, E. L., & Wolf, M. M. (1973). Achievement Place: Experiments in self-government with pre-delinquents. Journal of Applied Behavior Analysis, 6, 31-47.

Ford, T. E. (1980). A classification system for feedback procedures. Journal of Organizational Behavior Management, 2, 183-191.

Gilbert, T. F. (1978). Human competence: Engineering worthy performance. New York: McGraw-Hill.

Komaki, J., Blood, M. R., and Holder, D. (1980). Fostering friendliness in a fast food franchize. Journal of Organizational Behavior Management, 2, 151-164.

Komaki, J., Heinzmann, A. T., & Lawson, L. (1980). Effect of training and feedback: Component analysis of a behavioral safety program. Journal of Applied Psychology, 65, 261-270.

Kopolow, L. E. (1981). Client participation in mental health service delivery. Community Mental Health Journal, 17, 46-53.

Krumhaus, K. M., & Malott, R. W. (1980). The effects of modeling and delayed feedback in staff training. Journal of Organizational Behavior Management, 2, 279-293.

Lamb, H. R., & Goertzel, V. (1972). High expectations of long-term ex-state hospital patients. American Journal of Psychology, 129, 471-475.

Miller, L. K., & Miller, O. L. (1970). Reinforcing self-help group activities of welfare recipients. Journal of Applied Behavior Analysis, 9, 57-64.

Moos, R. H. (1981a). Environmental choice and control in community care settings for older people. Journal of Applied Social Psychology, 11, 23-43. (1)

Moos, R. H. (1981b). Group environment scale manual. Palo Alto: Consulting Psychologists Press, Inc.

Morrison, J. K., & Cometa, M. S. (1979). The impact of a client advisory board on a community mental health clinic. In J. K. Morrison (Ed.) A consumer approach to community psychology, 113-122. Chicago: Nelson-Hall.

Morrison, J. K., & Gaviria, B. L. (1979). The role of the client consumer in the delivery of psychiatric services. In J. K. Morrison (Ed.) A consumer approach to community psychology, 14-29. Chicago: Nelson-Hall.

O'Brien, F., Azrin, N. H., & Hensen, K. (1969). Increased communications of chronic mental patients by reinforcement and by response priming. Journal of Applied Behavior Analysis, 2, 23-29.

Panyon, M., Boozer, H., & Morris, N. (1970). Feedback to attendants as a reinforcer for applying operant techniques. Journal of Applied Behavioral Analysis, 3, 1-4.

Prue, D. M., & Fairbank, J. A. (1981). Performance feedback in organizational management: A review. Journal of Organizational Behavior Management, 3, 1-16.

Prue, D. M., Krapfl, J. E., Noah, J. C., Cannon, S., & Maley, R. F. (1980). Managing the treatment activities of state hospital staff. Journal of Organizational Behavior Management, 2, 165-181.

Quilitch, H. R. (1978). Using a simple feedback procedure to reinforce the submission of written suggestions by mental health employees. Journal of Organizational Behavior Management, 1, 155-163.

Runnion, A., Johnson, T., & McWhorter, J. (1978). The effects of feedback and reinforcement on truck turnaround time in materials transportation. Journal of Organizational Behavior Management, 1, 110-117.

Simons, L. S., Morton, T. L., Wade, T. C., & McSharry, D. M. (1978). Treatment outcome and follow-up based on client case records in a mental health center. Journal of Consulting and Clinical Psychology, 46, 246-251.

Stein, L. I., & Test, M. A. (1978). An alternative to mental hospital treatment. In L. I. Stein & M. A. Test (Eds.), Alternatives to mental hospital treatment. 43-55. New York: Plenum Press.

Windle, C., & Paschall, N. S. (1981). Client participation in CMHC program evaluation: Increasing incidence, inadequate involvement. Community Mental Health Journal, 17, 66-76.

Appendix A

Activities-Task Analysis

POTLUCK - Scheduled the last Saturday of every month, 1:00 p.m. Each underlined term such as menu should appear as an agenda item.

*Items are tasks to be worked on outside of the meeting.

**Items may optionally be worked on during or outside the meeting.

***Items require a decision to be made within the meeting or deferrment to another meeting.

Time Line	Task	
Two meetings before event	***(1)	Decide on menu. $30.00 available. Expect 50 people.
	**(2)	Make up shopping list. Include all items necessary for menu and service.
	***(3)	Allocate Responsibilities.
		*Shopping-Assign person, agree on day, get money from Bob, arrange transportation, shop, bring groceries to Center, give receipt to Bob or treasurer.
		*Cooking-Prepare food.
		*Set up-Get out extra chairs and folding tables. Set up in empty

Appendix A

Time Line	Task	
		floor areas.
		*Serving-Put food on serving counter. Dish food onto members plates from serving counter. Serve seconds at agreed on time.
		*Kitchen clean up-Wash dishes. Put away food, dishes, and serving utensils. Wipe clean tables, kitchen serving counters, and stove.
		*Center clean up-Put away extra chairs and tables. Clear tables and chairs of trash. Sweep floor.
		*Publicity-Make poster including date, time, and event one week before event. Contact key board and care homes about one week before event informing them of the event and ask if their people would like to come. Contact again one or two days before the event.
One meeting before event.	***(4)	Check potluck responsibilities-Make sure everyone is going to be able to complete their assigned tasks.

Appendix A

COFFEE AND SODA SALES-Scheduled Monday through Friday each week. 10:00 am - 12:00 pm.

Each underlined term such as supplies report should appear as an agenda item.

Time Line	Task	
Weekly	***(1)	Supplies report. Determine needed items. Assign responsibility for purchase of needed supplies if needed.
	***(2)	Sales check. Make sure everyone is going to be able to sell on their assigned day for the upcoming week.
As required	*	Supply purchase. Get money from Bob. Purchase supplies. Put in Council cupboard. Give Bob the receipt.

DANCE - Scheduled the second Friday of each month.

Each underlined term such as refreshments should appear as agenda item.

* Items are tasks to be worked on outside of the meeting.

** Items may optionally be worked on during or outside the meetings.

Appendix A

*** Items require a decision to be made within the meeting or deferrment to another meeting.

Time Line	Task
Two meetings before event	***(1) Decide on refreshments. ($15.00)
	**(2) Decide on shopping list. Include all items necessary for food and service.
	***(3) Allocate responsibilities.
	*Shopping. Assign person, agree on day, get money from Bob, arrange transportation, shop, bring groceries to Center, give receipt to Bob or treasurer.
	*Refreshment preparation. Get food ready to serve. Make sandwiches (if being served), get chips, etc., ready to put on counter.
	*Serving. Put refreshments in serving dishes; if necessary, put out on serving counter. Replenish as necessary until supplies run out.
	*Set up. Move chairs and tables to arrange a sitting area and a dance area.

Appendix A

Time Line	Task
	*Kitchen clean up. Wash dishes. Put away food, dishes, and serving utensils. Wipe clean tables, kitchen serving counters, and stove.
	*Center clean up. Put away extra chairs and tables. Clear tables and chairs of trash. Sweep floor.
	*Publicity. Make poster including date, time, and event one week before event. Contact key board and care homes about one week before event informing them of the event and ask if their people would like to come. Contact again one or two days before the event.
***(4)	Check Dance responsibilities. Make sure everyone is going to be able to complete their assigned tasks.

Appendix B

Communication-Task Analysis

STATE OF THE CENTER REPORT-Schedule: To be turned in monthly to the Center Director.

Each underlined term such as Make up questions should appear as an agenda item.

* Items are tasks to be worked on outside of the meeting.

** Items may optionally be worked on during or outside the meeting.

*** Items require a decision to be made within the meeting or deferrment to another meeting.

Time Line	Task
Meeting 1	***(1) Make up list of possible questions. Include at lease five on list.
	***(2) Make final selection of at least two questions.
	***(3) Decide who will compile the final report.
	***(4) Decide on number of people each Council member will interview.
	***(5) Submit final list of questions to the Center Director right after meeting for approval. Have Center secretary type list and make 7 copies.
Meeting 2	***(6) Hand out question list. Go over procedure (Tasks 7 and 8).

Appendix B

Time Line	Task
*(7)	Council members interview members. Ask each person interviewed each question. Write down answers.
*(8)	Council members submit answers to person responsible for compiling results.
*(9)	Compile results. Information gathered from other sources such as the meeting, unsolicited comments included. Submit to Director.

Example format:

Question #1: "What would you like to see Council money spent for?"

Answers:

(1) Fruit (1 person)

(2) Better dances (3 people)

Question #2: "What would you like to see changed at the Center?"

Answers:

(1) Get rid of drug dealers (3 people)

(2) Have more activities (1 person)

Appendix B

Time Line	Task
	(3) Get rid of partitions (1 person)
	(4) Level the pool table (1 person)
	Other information:
	(1) "We should go camping this summer." (Unsolicited comment)
Meeting 3	***(10) Check on report. Verify answers were submitted, State of the Center Report compiled and submitted to the Center Director.
Meeting 4	***(11) Director's response to State of the Center Report.

Appendix C

Program Planning-Task Analysis

PROGRAM PLANNING-Schedule: To be turned in monthly to the Center Director.

Each underlined term such as Council Action should appear as an agenda item.

* Items are tasks to be worked on outside of the meeting.

** Items may optionally be worked on during or outside the meeting.

*** Items require a decision to be made within the meeting or deferrment to another meeting.

Time Line	Task	
Meeting 1	***(1)	Topic related to Center objectives as defined by the director's memo included on agenda for discussion. Council should approve, disapprove, or defer the topic to another meeting.
	*(2)	Outside tasks such as information gathering may be assigned as needed.
	*(3)	Council Action written and submitted to the Center Director with a copy to the Council Chairperson including these specifics: a) Details of recommendation; b) Advantages and

Appendix C

Time Line		Task
		disadvantages of recommendation; c) Why the particular decision was made; d) Whose idea it was originally; e) What the vote of the Council was. A Council Action must be submitted for each topic related to Center objectives included on the agenda within a week of a Council decision being made. The Director has two weeks to respond.
Meeting 3	***(4)	Council considers Director's response to the Council Action and decides on the necessary action based on the following possibilities. 1) Planning is completed-including, if needed, an analysis of the tasks which must be completed to implement the plan. No further action is taken. The plan may become an Activity. 2) Further planning is needed.

Appendix C

Time Line	Task
	Council may return to Step (2) if further information is needed or Step (3) if specifics need clarification. Ongoing agenda items should be included as needed to reach Step (4) #1, planning is completed.

Appendix D

Member Advisory Council (MAC) Participation Rating Scale

General Instructions. If a Council member organizes or directs work on a task and general Center members carry through with the work, rate exactly as you would if the work was being done by Council members. Be aware of any staff direction given if no Council members are present including telling workers where things are and checking with them frequently to make sure all is going well. If members not on the Council work on a task but are not organized or directed by a Council member even though a Council member(s) is working on the task, rate the percentage of total work done by Council member(s) and the level of independence of the Council member(s). If a task is worked on by Center members with no Council member participating rate the task at 0 (TWRS) or at DNA (TSDRS). If a member offers to help with a task it is necessary for accurate rating for staff to refer the prospective helper to the Council member working on the task. The Council member may choose to not have help, to have help and direct the helper, or to have help and leave the direction of the helper to staff.

Appendix D

MAC PARTICIPATION RATING SCALE

Staff completing form_____Activity_____Date_____

Task_____Includes_____

MAC TASK WORK RATING SUB-SCALE (TWRS)

Please circle the number, 0-6, which most clearly identifies the level of Council work on the specified task.

6-100% Council work. Council did all the work on this task.

5-80%-99% Council work. Council did almost all of the work on this task.

4-60%-79% Council work. Council clearly did most of the work on this task.

3-40%-59% Council work. Council did about one-half the work on this task.

2-20%-39% Council work. Although the Council clearly did less than half the work on this task, their contribution was significant.

1-1%-19% Council work. Council did very little work on this task.

0-0% Council work. Council did not work on this task.

Appendix D

MAC TASK SELF DIRECTION RATING SUB-SCALE (TSDRS)

Please circle the number, 0-6, which most closely identifies the level of Council self-direction on the specific task. This is not contingent on the amount of work done on the task by Council.

6-No prompts to work on the task or staff direction on how to do the task were needed. Council worked on this task on their own.

5-One prompt to work on the task and/or very minimal staff direction on how to do the task were needed. Council worked on this task almost entirely on their own.

4-Some staff direction on how to do this task and/or one of several prompts to work on the task were needed. Council was mostly able to work on this task on their own.

3-Substantial staff direction on how to do this task possibly included several prompts to work on the task was needed. Council worked on this task somewhat on their own.

2-A great deal of staff direction on how to do the task possibly included several prompts to work on the task were needed. Council worked on this task a little on their own.

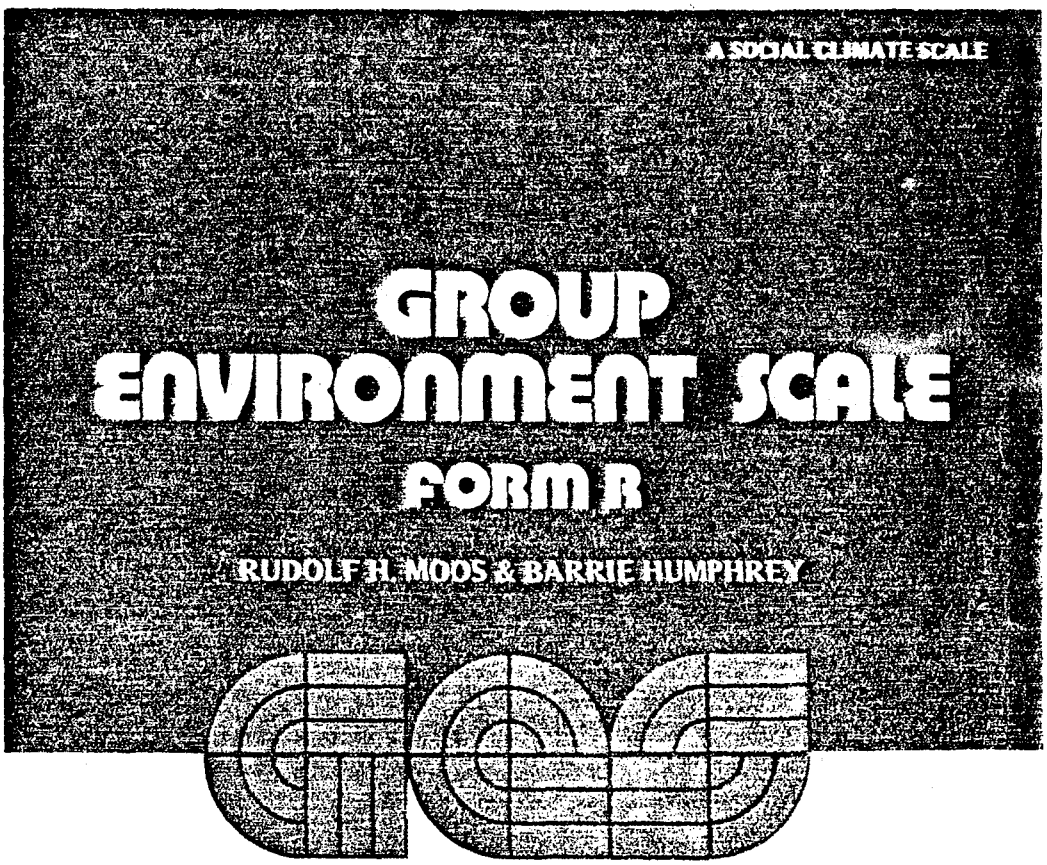
1-Council worked on this task almost totally following staff direction. Council did nery little of the work on this task on their own.

Appendix D

(TSDRS) cont'd.

0-Council worked on this task totally following staff direction. Council did none of the work on this task on their own.

DNA-Does not apply. Council received 0 score on TWRS. Council did not work on the task.



INSTRUCTIONS

There are 90 statements in this booklet. They are statements about groups.

You are to decide which statements are true of your group and which are not.

If you think the statement is True or mostly True of your group, make an X in the box labeled T (true). If you think the statement is False or mostly False of your group, make an X in the box labeled F (false).

Please be sure to answer every item.

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1. There is a feeling of unity and cohesion in this group.
2. The leader spends very little time encouraging members.
3. When members disagree with each other, they usually say so.
4. Individual talents are recognized and encouraged in this group.
5. There is very little emphasis on practical tasks in this group.
6. Personal problems are openly talked about.
7. Members are often critical of other members.
8. The activities of the group are carefully planned.
9. This group is run in a pretty loose way.
10. Things are pretty routine in this group most of the time.
11. There is very little group spirit among members.
12. The leader goes out of his way to help members.
13. It's hard to tell how members of this group are feeling.
14. In this group, members are learning to depend more on themselves.
15. This is a down-to-earth, practical group.
16. Members are expected to keep their personal hang-ups out of the group.
17. Members of this group rarely argue.
18. Each member has a clear idea of the group's goals.
19. The leader usually decides what the group will do next.
20. The group does very different things at different times.
21. There is a strong feeling of belongingness in this group.
22. The leader doesn't know the members very well.
23. Members often say the first thing that comes into their minds.
24. Everyone in this group is pretty much the same.
25. The group rarely has anything concrete to show for its efforts.
26. Members sometimes tell others about their feelings of self-doubt.
27. People in the group sometimes yell at each other.
28. It's sometimes hard to tell just what's going on in this group.
29. In a disagreement, the leader has the final say.
30. New approaches are often tried in this group.
31. Members of this group feel close to each other.
32. The leader explains things to the group.
33. Members show a good deal of caution and self-control in the group.
34. Most members "go along with the crowd."
35. This is a decision-making group.
36. Members sometimes talk about their dreams and ambitions.
37. Angry feelings are rarely expressed in this group.
38. There is a great deal of confusion in this group at times.
39. The leader enforces the rules of the group.
40. The group feels most comfortable with tried-and-true ways of doing things.
41. Members put a lot of energy into this group.
42. The leader helps new members get acquainted with the group.
43. Members tend to hide their feelings from one another.
44. Members are expected to take leadership in the group.
45. This is a planning group.
46. Members hardly ever discuss their sexual lives.
47. Members often gripe.
48. The rules of the group are clearly understood by members.
49. Members who break the group's rules are corrected by the leader.
50. This group always stays just about the same.
51. A lot of members just seem to be passing time in this group.
52. The leader takes a personal interest in the members.
53. It's o.k. to say whatever you want to in this group.
54. Members of this group are encouraged to act independently.
55. Relatively little work gets done in this group.
56. Members' religious beliefs are never discussed in the group.
57. Some members are quite hostile to other members.
58. This is a well-organized group.
59. The leader often gives in to pressure from the members.
60. People in this group are very interested in trying out new things.
61. The members are very proud of this group.
62. The leader doesn't expect much of the group.
63. There is a lot of spontaneous discussion in this group.
64. Members need the group's approval of their decisions before carrying them out.
65. This group concentrates on dealing with everyday problems.
66. Members can discuss family problems in the group.
67. The leader never starts arguments in group meetings.
68. The leader makes sure that discussions are always orderly.
69. Members may interrupt the leader when he is talking.
70. This group welcomes unusual ideas.
71. This is a rather apathetic group.
72. The leader tells members when they're doing well.
73. Members are careful about what they say.

74. The group helps members to become more self-reliant.
75. This group does not help its members make practical decisions.
76. In this group, you can find out what other people really think of you.
77. The leader sometimes gets angry at members of the group.
78. The group has an agenda for each meeting.
79. The leader has much more influence on the group than the other members do.
80. The group usually follows about the same pattern in every meeting.
81. The group is a good place to make friends.
82. Members can count on the leader to help them out of trouble.
83. People here think things out before saying anything.
84. There is a good deal of pressure to conform in this group.
85. The group helps its members learn new skills.
86. This group is a good place to "let off steam."
87. Some members are involved in petty quarrels with others.
88. Sometimes even the leader doesn't know what to do next.
89. The leader often tells members how to do things.
90. This group has a set way of doing things.