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DIFFERENTIAL ADHERENCE TO COMMUNITY
MENTAL HEALTH IDEOLOGY AMONG
FIRST YEAR SOCIAL WORK STUDENTS

A RESEARCH PRACTICUM BY LEO MUNTER
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE MASTER OF SOCIAL WORK DEGREE.

JACK FINLEY
PRACTICUM ADVISOR

PORTLAND STATE UNIVERSITY
1976

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ABSTRACT

Sixty first year students in the Portland State University School of Social Work were given the Baker--Schulberg Community Mental Health Ideology Scale. The resultant scores are reported for Community Mental Health Training Project (CMHTP) Students, Direct Service Students, and Planning Students. The Scores are compared with each other and with the original norming groups for the instrument. CMHTP students were found to have a significantly stronger adherence to the community mental health ideology than other students, but all groups examined were found to be sympathetic to the ideology.

ACKNOWLEDGMENTS

The first year students of the School of Social Work (class of 1977) deserve my thanks for allowing themselves to once again be the subject of student research. Dr. Fred Klopfer's assistance in my statistical hour of need was invaluable. Being guided through a T-formula over the phone was like being talked through a landing after your airplane pilot had died. I am extremely grateful to Vicki Barry and especially N. "Terry" Mussotto for their typing. It was an essential contribution which was offered on the basis of friendship, and that made it all the more appreciated.

My advisor, Jack Finley, who stimulated my activity with his sarcasm while communicating his respect through laissez-faire supervision was irreplaceable. His implicit and explicit support got this project over more than one hurdle. And finally, my appreciation, love, and so much more, goes to my wife who suffered more through this practicum than through her own Ph. D. thesis.

INTRODUCTION

Historical Development of Community Mental Health Ideology

The purpose of the instant project was to assess the degree of commitment to the values of a community mental health model on the part of first year graduate students in the Portland State University School of Social Work. Understanding these values in context necessitates an historical background on the development of the community mental health concept in the United States. (Bloom, 1973, Thomas and Clay, 1975).

The individualistic values of our founding fathers, and early resistance to governmental involvement in personal affairs was manifested in attitudes towards the "mentally ill." An individual so identified had to rely upon personal resources for care. These were primarily the nuclear and extended family, and in some cases the local community. For those too poor or too severely disturbed to be maintained within the family structure the only alternatives were prison, poor-houses, or some other form of non-treatment isolation.

As conditions for the institutionalized mentally ill deteriorated, there was a growing movement for some type of care facility specifically oriented to mental health service. In the mid-1800's, the pioneering work of Dorothea Dix resulted in the establishment of the first state mental hospitals in response to these conditions. A successful and genuine improvement at first, state supported hospitals soon were chronically overcrowded, understaffed and underfinanced. The quality

or care steadily declined until only custodial services were being rendered and the only apparent progress after 50 years was the governmental separation of the mentally ill from the criminal and other wards of the community.

In the 1920's the focus began to move from state responsibility and control. The primary harbinger of this change were the new child guidance clinics established as demonstration projects by the National Committee on Mental Hygiene in 1922. With treatment provided by a multi-disciplinary team, the child guidance clinic was intended to emphasize primary and secondary levels of intervention through early detection, education, and treatment, as opposed to the previously used tertiary interventions of rehabilitative, custodial services. Though limited in scope, the child guidance movement was important in reemphasizing the need for community involvement in community problems.

The federal awareness reflected by the National Committee on Mental Hygiene in 1922 was given further impetus during the depression years. One of the many legacies of the Public Works Administration is a series of mental hospitals. Prior to the 1930's this area had been the sole responsibility of individual state governments.

During the war years, the Veterans Administration established outpatient clinics and psychiatric hospitals to meet the needs of veterans. As with other areas of national growth stimulated by the war effort, the expansion of the federal commitment to mental health services was extraordinary. New facilities required new staff, and the federal government took an active role in the training of practitioners of varying disciplines. Many of today's established mental health professionals in psychiatry, psychology, social work, and nursing can look back to early

clinical training in Veterans Administration programs.

The National Mental Health Act of 1946 established the National Institute on Mental Health (NIMH). With the objectives of financing research, supporting professional training, and assisting in the establishment of community mental health facilities, the act was a major affirmation of local responsibility for service provision. At the same time, it clearly acknowledged federal responsibility for financial and technical support.

The 1950's brought the advent of new tranquilizing drugs, new and improved community programs, and the implementation of new administrative concepts within the mental hospital setting. As a consequence, many people receiving clinical services never had to enter a hospital. Those who were admitted stayed a shorter time. Finally, those patients who previously had been consigned to back wards as intractable were now, not only treatable, but in many cases discharged back to the community to be treated and maintained in a more normal setting. The stage was now set for the community mental health movement as we know it today.

In 1963 the Community Mental Health Centers Act was passed, providing funds for the construction of public, non-profit, voluntary community mental health centers. By federal mandate each center had to provide emergency mental health services, outpatient service, inpatient service, partial hospitalization care, and education and consultation functions. Expansion of services included diagnosis, pre- and post-hospitalization care, rehabilitation, and training, research and evaluation. In essence, the community mental health center was intended to provide a wide range of mental health services to small (75,000-200,000) group of people within a given community, with service available to all

its members. As a result of the large amount of expertise being provided to a relatively small population, the center could respond to idiosyncratic community problems with preventative and educational programs. This provided a new level of community involvement which established a model for the community action programs of the later 1960's.

In his book on the history of community mental health, Bloom (1973) cites nine characteristics of community mental health practice. These unique approaches serve to define community mental health ideology and distinguish this type of practice from the more traditional clinical/casework and community organization/planning approaches. The first characteristic is that the community mental health approach emphasizes community, as opposed to institutional, practice. Secondly, the service focus is the community opposed to selected individuals. Third, the approach recognizes and stresses prevention as a legitimate therapeutic intervention. Fourth, Bloom indicates community mental health practice is multi-faceted, offering consultation and training services for example, as well as direct clinical services. Fifth, the practice develops and uses innovative interventions, such as telephone hot lines in order to provide mental health services to more members of the community. Sixth, attempts are made to utilize community manpower through the use of para- and non-professionals, or community members in policy making positions. Seventh, there is an emphasis on rational, comprehensive planning for current and future community mental health service provision. Eighth, as part of this planning, unique community stress points are identified and attacked as opposed to only treating the individuals affected by the stress. The ninth, and last point which illustrates the community mental health ideology, is that this orientation has a commitment to community control.

Service is not provided to certain individuals in isolation, but is developed with and by the community, to meet community needs, and to benefit all community members.

Development of Graduate Social Work Education at Portland State University

After attempts in the 1930's and 1940's to develop social work education in Oregon--first at the University of Oregon, aborted by the depression, the second at Marylhurst, a casualty of World War II--the School of Social Work was established in 1961 at Portland State College by an act of the Oregon Legislature. The School was the first graduate program at the College and has gone on within 15 years to become one of the largest and most complex specialties offered, of which the Masters degree program is only a part. Historically the orientation of the School to graduate training has been a general one. An MSW practitioner would be so trained as to be able to function equally well in any mode of service. In actual practice, the 1967 Report for Reaffirmation of Accreditation indicated that students were trained primarily in social casework, with the integration of individual, group and family practice just being developed. However, the provision of training in planning and facilitative services was still a long range goal of the School. Throughout nearly all of the first decade of the School's existence, this study could not have been attempted as there were no separate curriculum options.

In the early 1970's, a community organization/social welfare planning speciality began to develop, but these years were a time of internal and external stress for the School. The university was affected by the student

revolts of that period. The School was under pressure to admit and develop curricula for minorities. The Council on Social Work Education, the accrediting organization for schools of social work, issued new policy statements which became a major force for change. By 1972, concern was being expressed that the School was changing in too reactive a fashion. Accordingly, the Curriculum Policy Committee of the School developed a model curriculum consisting of a generalized core of courses and the development of practice specialities, augmented by elective courses.

This move recognized the legitimacy of training for practice and was a major step toward the development of a separate planning/community organization track. In 1974-75 first year students still had courses in common, but by the 1975-76 academic year the curriculum was so organized that it was possible for incoming planning students and direct service students to not see each other from the orientation picnic to graduation exercises. The student body had developed sub-groups.

Throughout this history the role of the field practicum experience remained relatively consistent; it was to provide the student with practical experience. According to the Council on Social Work Education, it would enhance, integrate, and reinforce knowledge gained through course work. Field experience was seen as essential but implicitly adjunctive. There were some unique opportunities offered in the field, however. The Mental Health Act of 1960 enabled NIMH to provide funds for training in various aspects of mental health. The first funded field training was the Urban/Rural project funded in the early 1960's. A School Social Work project was added in 1968 to provide training experiences at Adams High School. In 1971 NIMH funded a Maternal and Child Health Training Project.

None of these projects stressed any course content; rather, they were conceptualized as providing specialized field experiences which might not otherwise be available.

By 1973 there was a clear need for greater response to the community mental health movement and a concomitant need for additional training efforts in the area. Accordingly, NIMH directed the School to coalesce the three existing projects into one coordinated Community Mental Health Training Project (CMHTP). While not an actual course of study, the CMHTP provides specialized field experiences, unique enrichment programming, linkage seminars, and some special courses for trainees. In addition, it emphasizes the applicability of standard course content to the community mental health model. The CMHTP selects students who already profess an interest in community mental health and, through the training, attempts to increase the student's knowledge, commitment and competency.

By the spring of 1976, this chronology had resulted in three relatively distinct groups of students enrolled in the first year program; students in the direct service track, students in the planning track, and those students receiving training and socialization as members of the CMHTP. It is these groups that this project attempts to examine.

METHODOLOGY AND RESULTS

Discussion of Instrument

The instrument used for this study was the Baker-Schulberg Community Mental Health Ideology Scale. Baker and Schulberg (1967) define ideology as "any systematically related set of beliefs held by a group of people, providing that the system of beliefs is sufficiently basic to the group's pattern of functioning". As noted earlier, there is clearly a systematic set of beliefs surrounding the issues of population, levels of intervention, scope of intervention, creativity and continuity of care, and citizen participation in treatment within the community mental health orientation. And these beliefs are indeed basic to the functioning of those committed to the orientation. The focus of this exploratory research was to consider the following questions:

1. There is a wide variety of roles available to the professional social worker today, and a similar variety of approaches to professional training at the School. But, are the basic values of the community mental health orientation fundamental to social service? If this is true, the professors who teach it, as well as those who select the field as their future profession, could be expected to rather uniformly hold and advocate the basic community mental health values.

2. Considering the opposite hypothesis (that students entering the field and beginning their professional training have yet to develop a systematically related set of beliefs that form the basis of their functioning) to what extent have students still at the apprenticeship

level developed a community mental health ideology by the end of one-third of their training?

3. Within a similar group of students, are there significant differences in the adherence to community mental health values between groups self-identified as direct service, planning, or community mental health project students?

The Baker-Schulberg Community Mental Health Ideology Scale (CHMI) consists of thirty-eight items, nineteen pro-ideology and nineteen anti-ideology, distributed randomly throughout the test. Respondents circle strongly, moderately, slightly agree/disagree on a forced choice Likert scale. The questionnaire is scored giving an appropriate one-to-seven value to each answer. There is no four, or neutral, value. The higher the total score the greater an individual's adherence to or belief in community mental health ideology. The test was normed on 484 individuals drawn from (1) graduates of the Harvard School of Public Health and Harvard Medical School Community Mental Health Training Program, (2) graduates of the Columbia University School of Public Health and Administrative Medicine, Division of Community Psychiatry Post-Doctoral Training Program, (3) Members of the Harvard Laboratory of Community Psychiatry Visiting Faculty Seminar (16 psychiatry professors in a three-year program at Harvard), (4) participants in the 1965 Swampscott Conference on Training in Community Psychology. Those four groups were selected for their assumed high orientation to community mental health values. A second group included in the 484 respondents consisted of randomly selected members of the American Psychological Association (Division of Clinical Psychology), the American Psychiatric Association and the American Occupational Therapy Association (Psychiatric Occupa-

tional Therapists). A third category completes the norming sample and was selected for its assumed negative bias towards community mental health. This group, comprising 46% of the sample was drawn from members of the American Psychoanalytic Association and the Society for Biological Psychiatry.

Mean scores for these nine groups ranged from a low of 194.52 for members of the American Psychoanalytic Association to a high of 239.79 for Harvard Public Health and Community Mental Health graduates.

In its use in this present project the CHMI was given to first year graduate students in social work during the fifth and sixth weeks of the third quarter of their training. The test was administered in Issues and Perspectives classes (a core class required of all students) to all full-time enrolled first-year students attending on that day.

Each administration was begun with a standardized introduction. "Hi. My name is Leo Munter. As part of my practicum I am giving this test to first year students. I do not need your names but I do need you to indicate your track where it says code number. Please indicate whether you are a planning, direct service, or Community Mental Health Project student. It is important that you answer every item. It is also important that you indicate your involvement with the Community Mental Health Project if you are a part of it. In order to maintain the integrity of my design I am not able to answer any questions while there are still people left to test. I'll be glad to discuss my project with anyone after my results are in. The test will take about ten minutes. Thanks for your cooperation."

RESULTS

The responses were scored and any subjects failing to answer more than two items, any answering an item twice, any questionnaires indicating both planning and direct service as their track, and any with obviously invalid responses (methodically progressing from strongly agree to strongly disagree through much of the test with a resultant mean score of 61, for example) were discarded. Those answering 37 of 38 were given the mean score of the 37 answers for the 38th response. After allowing for these, as well as absent students, there was a return of 60 tests which were divided into groups of 7 Community Mental Health Project students, 10 planning track and 43 direct service responses. The mean score for each group was determined and appears below:

	<u>N</u>	<u>$\bar{X}$</u>	<u>RANGE</u>	<u>s.d.</u>
COMMUNITY MENTAL HEALTH	7	246	229-258	10.52
DIRECT SERVICE	43	223	156-257	23.04
PLANNING	10	224	188-250	20.86

A chi-square test of significance could not be used due to the lack of enough responses for an adequate number in each cell. Accordingly a t-test for independent groups was used to measure significant difference between groups. The direct service and planning students were compared against each other and, as might be expected from examining the above data, no significant difference was found, ($t < .002$). On the basis of these scores the students not in the Community Mental Health Project could be considered to be a relatively homogeneous group. Nonetheless the scores of the Community Mental Health Project students

were compared against the two groups separately. When compared with the planning students the resultant $t=2.402$ was significant at the .05 level. When compared to the direct service students, the resultant t of 2.501 also shows the scores of Community Mental Health Project students to be significantly higher.

	<u>t</u>	.05	.01
COMMUNITY MENTAL HEALTH: PLANNING	2.402	2.131	2.624
COMMUNITY MENTAL HEALTH: DIRECT SERVICE	2.501	2.01	2.68

DISCUSSION

Three questions were posed at the outset. Are community mental health values a universal orientation for mental health practitioners? Could incoming students form a value orientation by the end of 27 weeks of school? Are there significant differences between direct service, planning, and community mental health students with regard to the community mental health ideology?

To take these out of order, the answer to the third question clearly appears to be yes, there are significant differences. Scores on the CMHI of Community Mental Health Project students average more than 20 points above those of non-project students. There are two possible explanations for this. First is the Community Mental Health Project selection process which is, in effect, a two level screening. Only those students with what an interest in community mental health work apply to the project in the first place. Thus, project staff select from that group those whom they feel hold the most promise for future community mental health work. The director of the project, Ms. June Dunn, estimates that half of those expressing an interest in the project are rejected. It is reasonable to expect that those selected have had their personal beliefs in community mental health work confirmed through acceptance to the project, and then begin training in the application of those beliefs. This training would obviously tend to reinforce the existing belief structure, providing the second explanation of higher scores. Thus, scores of Community Mental Health Project students which are significantly higher than those of their fellow students could be attributed to both their selection

and their training in the project.

For an answer to the question of the universality of community mental health beliefs, one must return to the norming work of Baker and Schulberg. The scores can be conceptualized in terms of ranges by taking the mean score for a consistent attitudinal response plus and minus half a range (19). Thus the range for "moderately agree" (score of 6) for example, would be $38 \times 6 \pm 19$ or 209 - 247. "Strongly agree" would range from 248 to the top limit score of 266. Applying this range concept to the nine groups (484 respondents) that the test was normed upon, Baker and Schulberg report that none of the norm groups mean scores were in the "strongly agree" range. Five of the nine norm group mean scores fell in the 209-247 "moderately agree" range:

Harvard post-Doctorals	$\bar{X}=240$
Harvard visiting faculty	$\bar{X}=235$
Community Psychologists	$\bar{X}=234$
Columbia post-Doctorals	$\bar{X}=221$
American Psychological Association Clinical	$\bar{X}=218$

In fact, all of the four remaining norm groups, including the assumed to be negative American Psychoanalytic Association, had scores in the top half of the 171-208 "slightly agree" range:

American Occupational Therapy Association	$\bar{X}=208$
Society for Biological Psychiatry	$\bar{X}=206$
American Psychiatric Association	$\bar{X}=199$
American Psychoanalytic Association	$\bar{X}=195$

Baker and Schulberg recommended further research on nurses, social workers and other mental health professionals but their selection of psychiatrists, psychologists, and occupational therapists, as well as the scores from the research at hand, tend to point to some tentative conclusions regarding universality. Rather than distinguish between adherents of the new ideology as opposed to those associated with tradition, the CMHI seems to discriminate between levels of adherence to what appears to be a relatively universal belief structure surrounding the delivery of mental health services. Individual practitioners may hold different specialities, and even deliver their own services in a mode other than that conceptualized in the community mental health model, but there seems to be a consensually strong agreement about enough specific issues to pull mean scores for a wide variety of mental health groups up to the moderate to slightly agree range. In other words there were enough highly scored (7 and 6) responses to bring the average score per response to $6 \pm .5$.

It is interesting to look at those consistent "strongly agree" items as responded to by the norming group and compare their scores with that of School of Social Work Students. The three items (and the individual items mean score) normed to have the strongest positive response from Baker and Schulberg's 484 subjects were:

10. The mental health specialist should seek to extend his affectiveness by working through other people. ($\bar{X}=6.48$.)

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

ill. ($\bar{X}=6.40$.)

25. The mental health center is only one part of a comprehensive

community mental health program. ($\bar{X}=6.43$.)

The mean scores indicate that even those presumed to be most negatively predisposed to community mental health values had to express some degree of agreement with these principles. The question arises, are these three statements actually reflective of community mental health ideological tenets? Referring to the previously cited characteristics of community mental health practice described by Bloom it is clear that statements 10 and 21 explicate the fourth and sixth characteristics of community mental health practice being training and consultation as well as direct intervention and of the community mental health model relying upon community manpower for service delivery. Statement 25 would seem to reflect Bloom's first characteristic that community mental health practice emphasizes community, as opposed to institutional practice.

The scores of the three student groups on items 10, 21, and 25 were meaned for comparison with Baker and Schulberg's 484 subjects. The results appear below:

MEAN SCORE ON ITEM

Item	Baker-Schulberg	CMHTP	Direct Service	Planning	All students
10	6.48	6.57	5.98	5.60	5.98
21	6.40	6.71	6.14	5.90	6.17
25	6.43	6.86	6.26	6.50	6.37

Although the composite student scores are lower than those of the CMHI norming population they are still in the "moderately agree" range as are those of Baker and Schulberg's subjects. The scores for Community Mental Health Training Project students exceed those of all other groups

consistently falling in the "strongly agree" range. This would seem to validate the contention that a variety of mental health professionals would support the values of community mental health practitioners, but that those actually engaged in community mental health work would naturally be more invested in the ideology and manifest their adherence more clearly on the CMHI.

It appears that the CMHI tests what it intends to test. That is, the ideological statements do in fact reflect a systematic set of beliefs surrounding this type of practice. It has also been surmised that there is reason to believe that these community mental health values are held to varying degrees by persons not engaged in community mental health work. The varying degrees of adherence in the groups of students tested for this study showed significant differences between those students who were part of the community mental health training project and those who were not. The third of the three initial questions, could incoming students form a value orientation by the end of 27 weeks of school, remains as the most difficult to discuss.

To the extent that the community mental health ideology could be called a value orientation, it seems apparent that the first year students have adopted it to varying extents. But many unanswerable questions arise. A value orientation should form the basis for action. It is unknown whether the first year students--other than those in the Community Mental Health Training Project--would take any action based on their beliefs. Obviously those in the Training Project took action based on their value orientation by applying to the Training Project. It is not known what score separates those who believe strongly enough to act and those who merely feel the community mental health approach has merit.

Some of those who scored highly in the direct service and planning student groups may have been those who were not accepted by the Training Project yet still felt committed enough to apply.

To some extent this discussion begs the question. For even if it is conceded that some students were found to have a value orientation when tested at 27 weeks, it is not known whether it was developed as a result of their education and training. It is reasonable to conjecture that students with an exceptionally strong commitment to community health entered the school with that commitment. One could even hypothesize that in 27 weeks of exposure to alternative approaches, their resolve may have been mitigated to some degree. Thus the third question remains unanswerable at this time, but does point the way to areas for further research.

IMPLICATIONS FOR FURTHER RESEARCH

As indicated above, one of the biggest unknowns is the effect of graduate education on community mental health ideology. Ideally, the CMHI would be one of several tests given to students when they were accepted to the school. (The results of which would be used only for research, not student selection.) It would be valuable to know the professional background of the subjects as it may be surmised to have considerable bearing on their professional values. The relationship between community mental health values and prior experience in entering students would in itself be interesting research. Further, if faculty were also tested, research could be done on the differential development of ideology between students who mainly took classes from high scoring professors and those taking classes from low scoring professors. One could also monitor ideological development over time to determine the effect of summer vacations, block placements, and other variables impinging on selected students or the class as a whole. If testing were done consistently, longitudinal data, unobtainable through other means, might open new realms of study. Students could be tested upon completion of their studies to be compared with initial scores on an individual basis. This would allow for the effect of individually developed learning experiences--such as prior employment, or special field programming--to be differentiated from the effect of the MSW program as a whole on the development of the community mental health ideology.

Another area of research stems from the assumptions described above. The main assumption is that of universality. This present project appears

to have generated a strong circumstantial argument in favor of the universality of community mental health ideology among mental health professionals, at least as determined by the CMHI. But in order to place the research described earlier in a meaningful context, there needs to be substantially more data generated on student scores, scores of practicing social workers (particularly as differentiated by activity, interest and practice area, and length of time in the profession), and more comparison data between social workers and other mental health professionals, as Baker and Schulberg attempted in their norming work with psychiatrist, psychologists and occupational therapists.

In conclusion, this study has shown the Baker-Schulberg Community Mental Health Ideology Scale to be valuable and easy to use in the area of professional attitudes and beliefs. A clear case has been made for further research. That research involving the testing of existing professionals in practice, and in various disciplines, could be done easily and profitably by second year students as research practica. But the most valuable data, the individual scores made before entering school and accompanied by some background information, can only be obtained if a clear commitment to student research is made on the part of the School of Social Work. For if such information were to be fully utilized it would have to be consistently obtained, under standardized procedures, with a reverence for methodology which would transcend the personalities of those involved with the admissions process.

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Code Number. _____

BAKER-SCHULBERG CMHI SCALE

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

Circle *AAA*, if you *strongly* agree
 Circle *AA*, if you *moderately* agree
 Circle *A*, if you *slightly* agree

Circle *DDD*, if you *strongly* disagree
 Circle *DD*, if you *moderately* disagree
 Circle *D*, if you *slightly* disagree

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

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

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

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